

# 4 The relevant markets and the effects of the proposed merger

## Contents

	<i>Page</i>
Introduction .....	77
The private acute healthcare sector—a general overview .....	78
NHS healthcare .....	79
Consultants (referral process and role of consultants, BUPA’s Consultant Partnership Scheme) .....	80
Market conditions and imperfections .....	84
Vertical linkages (ownership links/integration, preferred PMS providers, networks and other linkages) .....	85
Market definition .....	87
PMI market .....	92
Policies, prices, networks and competition .....	93
Sales, PMI providers and market shares .....	95
Entry conditions .....	97
Networks and preferred provider arrangements .....	98
PMS national market analysis .....	101
Sales revenues, market shares and capacity .....	101
Hospital charges .....	104
Entry conditions .....	109
PMS local markets and wider areas .....	110
Local area analysis by BUPA and the OFT .....	110
Definition of areas .....	111
Solus hospitals .....	113
BUPA/CHG overlap areas .....	115
Flagship hospitals .....	117
Wider areas .....	117

## Introduction

4.1. This chapter examines the relevant markets (or areas of economic activity) in this inquiry and the expected effects of the proposed merger between BUPA and CHG in those markets. SSSB companies (see Chapter 3) are also parties to this inquiry but none is active or has any interests in any of the relevant markets, so we do not consider them further in this chapter.

4.2. We start by providing an overview of the private acute healthcare sector in the UK—and particularly the changes that have occurred in recent years—with regard to the nature of the treatments and services provided, the operation of private hospitals and medical insurance, consumer demand, the role of consultants, and general market imperfections. We then consider vertical integration and the other important vertical linkages between PMI and PMS, again with particular regard to the changes in the relevant markets that have occurred in recent years. Following that, we set out our reasoning on the product and geographic definitions of the PMI and PMS markets. Against that background, we move on to evaluate separately the PMI market (in terms of products, sales and market shares, hospital networks and charges, and entry conditions); and PMS markets at both the national and local levels, including the effects of the proposed merger on competition.

4.3. BUPA, CHG and SBUKE are considered in Chapter 3, which also deals with some aspects of financial performance and efficiency, together with the reasons for and claimed benefits from the proposed merger between BUPA and CHG. The views of main parties and third parties are considered in Chapters 5 and 6 respectively. A glossary of terms is included at the end of the report.

## **The private acute healthcare sector—a general overview**

4.4. Private healthcare and related services have been considered and reported on by the MMC in two previous inquiries, namely that on the BUPA/HCA merger (in 1990) and a complex monopoly inquiry on medical consultants' fees (in 1994); see Appendix 4.1, items 1 and 2. The OFT also undertook a review of some aspects of this sector in 1999 (see Appendix 4.2). Other relevant reports on the UK healthcare sector, notably those by Laing & Buisson (which were cited by many of those who gave evidence to us, including both main parties), are also listed in Appendix 4.1.

4.5. As explained in the earlier MMC reports (as well as those by Laing & Buisson), private acute hospitals are privately-funded hospitals which admit patients (including both those covered by PMI and self-paying patients) for surgical operations and other medical treatments. They also commonly provide outpatient and day-case treatment where a hospital stay is not required (about 50 per cent of patients treated do not need overnight accommodation). These hospitals are serviced by the 16,000 or so NHS consultants who engage in private practice on a part-time basis, in addition to their main work within NHS Trust hospitals. The total value of such private treatment services is currently about £2.3 billion a year—more than double the level of ten years ago in cash of the year terms—of which hospital charges (for PMS) account for around two-thirds and consultants' fees about one-third.

4.6. Private hospitals are highly dependent on attracting consultants undertaking private practice to use their facilities for the treatment of patients referred to them by GPs. In general, it is the consultant to whom a patient is referred by his or her GP who has the most direct influence in determining the private hospital at which the patient will be treated. Most patients accept the consultant's guidance on this, though many insured patients may be limited by their insurance cover to particular hospitals in their local area (under so-called 'network' policies or 'preferred provider' arrangements, both of which were introduced and have grown in importance during the 1990s).

4.7. The services that private hospitals provide include accommodation, ie patients' bedrooms, typically with en suite bathrooms; diagnostic equipment (for example, magnetic resource imaging (MRI) and computed tomography (CT); see glossary) and related services; theatre operating facilities and equipment; nursing care, dressings and drugs. Hospital costs and charges are considered further in paragraphs 4.137 to 4.156. Private hospitals rarely themselves employ consultants, but they generally employ other doctors to provide resident medical cover on-site.

4.8. Medical procedures performed in private acute hospitals are mainly 'elective' surgery, meaning that the patient's condition is not life-threatening and is such as to allow some choice as to the timing of the operation. Most such private hospitals provide a wide range of treatments, the most common types of elective surgery undertaken in private acute hospitals being: endoscopic examinations (see glossary); hysterectomies; skin and subcutaneous tissue operations; cataract removal; hernia repairs; varicose vein treatment; hip replacements; and coronary artery bypass grafts. The total costs of such treatments (including both hospital charges and consultants' fees) are often in the range of £1,500 to £3,000, though hip replacements typically cost around £7,000 to £8,000, and heart operations substantially more.

4.9. Private hospitals typically concentrate on the type of elective acute surgery for which the NHS is likely to have the longest waiting lists—privately paid treatment does not involve serious delays. Demand for treatment in private hospitals—which tends to be price inelastic (see paragraph 4.75)—comes also from patients wanting a higher standard of comfort and privacy than is generally available to NHS patients, more flexibility regarding the timing of their hospital stay, and greater choice of consultant.

4.10. There are currently about 230 private hospitals (excluding psychiatric hospitals) in the UK, with a total of nearly 11,000 beds. Of these, a dozen or so are specialist hospitals or clinics dealing only with infertility treatment, pregnancy terminations or cosmetic surgery, rather than the full range of elective surgery. As detailed later (see paragraph 4.126), if both these single treatment clinics and the psychiatric hospitals are excluded, there are some 216 private acute hospitals in the UK, the total number of

beds currently available being around 10,300. A typical private hospital (both the median and average size) comprises two operating theatres and about 50 patient beds, the average occupancy of which—measured as the proportion of beds occupied overnight on average throughout the year—is 50 per cent or so. We consider hospital capacity in more detail in paragraph 4.135.

4.11. In addition to private acute hospitals themselves, private medical treatment is also available to patients within NHS Trust hospitals. NHS provision of ‘pay-beds’ is long established, but since the late 1980s the NHS has set up some 97 PPUs dedicated to the treatment of private patients. In total, these PPUs comprise about 1,500 private beds. The pay-beds in NHS wards are authorized for private treatment when not being used for NHS patients. The NHS also uses the private sector to a limited extent, particularly when demand exceeds its own capacity. Private hospital revenues from NHS work typically account for less than 3 per cent of their total income (for example, about 2 per cent or less in the case of CHG hospitals).

4.12. A significant factor behind the existence and growth of private acute hospitals (and private treatment in NHS PPUs) has been PMI. Overall, about 75 to 80 per cent of patients treated privately are covered by PMI (though in London the proportion is nearer 50 per cent, because there are more patients from overseas). Of these insured patients, about two-thirds are covered under policies paid for by their employers (though this corporate sector accounts for only 40 per cent or so of PMI revenues; see paragraph 4.77). The size of the PMS sector and the rate at which it can grow is therefore heavily (albeit not entirely) dependent on the numbers of individuals who are covered by PMI. That said, self-paying patients account for 20 to 25 per cent of PMS revenues, and demand from this sector has in recent years been growing rather faster than the insured sector (see Laing & Buisson, Appendix 4.1, item 8): BUPA told us that self-pay demand may soon rise to the levels last seen in the early 1980s.

4.13. Notwithstanding the growth in PMS over the past two decades, the NHS continues to provide the vast majority of surgical and medical treatment in the UK and deals with virtually all accidents and emergencies which, in the main, the private acute hospitals do not cover. Indeed, the NHS currently has around 150,000 acute sector beds, nearly 15 times the current number of beds in private acute hospitals. The majority of the population requiring hospital treatment (of which many may not be able to afford private treatment) will obtain it at no charge in an NHS hospital—a factor which greatly influences the size and scope for development of the PMS.

4.14. Both the PMI and PMS markets have evolved considerably during the 1990s. Some of the key changes that have taken place which are relevant to this inquiry include: the entry and expansion of commercial insurers (and also possibly TPAs—see paragraph 4.59); the growth in concentration of ownership within the private acute hospitals sector; the development of large hospital groups operating on a nationwide basis; the associated reduction in the ability of the stand-alone, independent hospitals to compete (see paragraph 4.115); and the continual increases in both medical treatment costs (which may partly reflect technical advances in medicine) and PMI policy premium costs (which tend to reflect increases in treatment costs). Also of importance have been the changes in the nature and strength of the vertical linkages between the PMI and PMS markets, including: the growth in BUPA’s PMS business alongside its continued presence in PMI; the introduction of PMI ‘network’ policies and other preferred provider arrangements (see paragraphs 4.108 to 4.121); the trend towards hospital charges to PMI providers being set through annual negotiations largely (but not wholly) on a national average rather than a local or regional basis (see paragraph 4.138); the growing influence of the major PMI providers over PMS (through cost and quality assessment procedures, as well as so-called pre-authorization arrangements—see paragraph 4.27); the introduction of BUPA’s CPS (see paragraph 4.31); and the effects of its Benefit Maxima scale of fees (see paragraphs 4.31 to 4.39). Reflecting these changes and developments, there has also been increasing interest in both PMI and PMS markets by the competition authorities.

## **NHS healthcare**

4.15. As indicated in our earlier report on the BUPA/HCA merger (see Appendix 4.1, item 1), the NHS has long had pay-beds for use by private patients but, as mentioned in paragraph 4.11, there were significant developments in PMS provision by the NHS during the 1990s. Until 1997, this was accompanied by increased activity by the NHS in the PMS market, and also greater use of private PMS facilities by the NHS itself. Indeed, BUPA told us that the NHS PPUs constituted a significant and growing competitive force in the PMS market; that they had access to the clinical infrastructure of the main NHS hospital which was not available to private hospitals; but that BUPA PMI felt their charges often failed to

reflect an accurate view of costs.<sup>1</sup> In some cases, however, PPU have been able, BUPA told us, to compete successfully against private hospitals for inclusion in PMI networks (for example, the networks of PPP and Norwich Union—see paragraph 4.112).

4.16. In contrast to that view, Laing & Buisson told us that the PPUs did not offer effective competition to private hospitals, particularly to the major PMS groups (GHG, BUPA, Nuffield and CHG). They were typically small units, one-third the size of most private acute hospitals, and were operated according to the particular policies of the NHS Trusts concerned. As a result, competitive performance varied and there was no centralized strategy for marketing, pricing and commercial development. They also pointed out that a substantial proportion of all PPU revenues arose in the London area, and that their market influence outside London was generally rather marginal (albeit with some exceptions).

4.17. Following the change of government in 1997, the policy emphasis within the NHS has shifted more towards improving standards (and reducing waiting lists, in particular) in its mainstream NHS service provision. Indeed, the Government has recently announced a major development plan for the NHS, accompanied by significant increases in funding. A summary of this (*The NHS Plan*) is included at Appendix 4.3.

4.18. The relevance of *The NHS Plan* to this inquiry derives from the likely impacts of an improved public service on demand for PMI and PMS, including demand for PMS from the NHS itself. The NHS Plan clearly involves a major increase in resources for the NHS, some of the key elements being: expenditure to increase by one-third in real terms over the next five years; an extra 100 hospitals and 7,000 beds; an extra 7,500 consultants; and 20,000 extra nurses. Among the planned improvements in service standards are a marked reduction in waiting times for both inpatient and outpatient treatment in NHS hospitals, which—when achieved, and seen by the public to have been achieved—may indeed tend to reduce demand for PMI/PMS.

4.19. But these proposals relate to a five-year period and so will take time to be fully implemented. Some aspects, too, have attracted criticism, for example the proposals to restrict newly-qualified consultants to NHS work only. To meet its service delivery objectives the NHS may also (under the provisions of the NHS Plan and an official concordat signed by the Secretary of State for Health and representatives of the private sector on 31 October 2000) make greater use of private hospital facilities and capacity (where this, in the words of the Plan, ‘provides value for money and maintains standards of patient care’).

## **Consultants (referral process and role of consultants, BUPA’s Consultant Partnership Scheme)**

4.20. Consultants are registered medical practitioners who have been granted specialist recognition by the General Medical Council and who hold or have held or are eligible to hold a consultant post in the NHS. A recent House of Commons Health Committee report (see Appendix 4.1, item 7) estimated that there were currently about 23,000 accredited consultants employed under contract by the NHS (at an average NHS salary of £68,000 a year), covering more than a dozen different areas of speciality (including ear, nose and throat (ENT), urology, general surgery, obstetrics, anaesthetics etc). Of these, around 16,000 (or nearly 70 per cent) also undertook private practice work (as allowed for under consultants’ whole-time and maximum part-time contracts). There is considered to be a shortage of consultants in the UK (which affects both the NHS and the private sector), particularly in certain areas of speciality and also in some geographic areas. We note the Government’s intention under *The NHS Plan* to increase the number of consultants by 7,500 over the next few years. We note also the Health Committee’s concerns and recommendations with regard to the terms and conditions of NHS consultants’ contracts.

4.21. All NHS consultants, whatever their contract type, work most of the time on NHS duties; and there are very few consultants undertaking private practice who have not, or do not, hold NHS consultant posts. Within NHS hospitals, only about half of all surgical operations are performed by consultants (the others being undertaken, under supervision, by junior surgeons, with Specialist Registrar status); whereas all private medical procedures are undertaken by consultants. Indeed, the PMS providers ensure that only

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<sup>1</sup>BUPA also told us, however, that it was not able to negotiate discounts from PPUs which were comparable to those agreed with private acute hospitals, and this was one of the reasons why BUPA has not included any PPUs in its hospital network.

consultants who hold or have held or are eligible to hold an NHS consultant appointment are able to obtain admission rights to private sector acute hospitals; and only such consultants are permitted to provide private medical treatment services under the provisions of most PMI policies.

4.22. As mentioned earlier (paragraph 4.5), consultants' fees for private treatment services (medical examinations, surgical operations etc)—about £700 million a year—account for around one-third of the value of all private healthcare services. In 1989 the BMA began to publish guidelines for consultants' charges, but this was abandoned in 1994, following an MMC report (see Appendix 4.1, item 2). Since then, consultants' charges for private medical work have been more closely aligned with BUPA's Benefit Maxima (a schedule of maximum reimbursable fees, specified for each type of medical procedure, for example hernia repair or hysterectomy, which BUPA will normally pay). Average private sector earnings by consultants are around £40,000 to £45,000 a year though there is a wide range, with some earning less than £20,000 a year, whilst a small number—by inference the most active—may earn in excess of £400,000 a year.

4.23. In order to see a consultant, whether as an NHS patient or with a view to having privately paid-for treatment, all patients normally need to be referred by their GPs, who will typically recommend a suitable consultant of whom they are aware, and who is employed in an NHS Trust hospital, usually within the same local area. In most cases, patients have little or no knowledge of individual consultants. The GP therefore has a crucial role in the initial decision as to which consultant a patient will be referred. NHS patients will normally face a waiting list and a delay of several months before seeing a consultant: currently, the number of NHS patients waiting more than 13 weeks for a first outpatient appointment with a consultant is over 400,000. After seeing the consultant, NHS patients also generally face waiting lists and a potentially lengthy delay before receiving treatment in an NHS hospital, particularly for elective surgery. By contrast, most private patients are seen by a consultant within two weeks of GP referral, and do not face any delay before getting treatment.

4.24. Where a private patient has been seen by a consultant and treatment is deemed to be required, the consultant, as mentioned previously, has a degree of influence in determining which private hospital to use. In some areas, there may in practice be only one private hospital available (ie solus areas—see paragraph 4.40). More commonly, however, there are likely to be alternative, competing hospitals available, and consultants typically have admission rights to more than one hospital in the local area. Consultants, often have professional or personal preferences for particular private hospitals, and they will therefore generally seek to treat their patients there. Most patients accept the consultant's guidance on which hospital to use, though insured patients may in practice be limited by their insurance cover to particular hospitals in their local area (under network policies or a preferred provider arrangement—see paragraphs 4.108 to 4.121), or to hospitals offering accommodation falling within particular price bands (see paragraph 4.80). The existence of such networks and associated PMI policies, as well as the inconvenience to consultants of splitting their patient lists between different hospitals, is likely to encourage consultants to carry out more of their work at network hospitals, ie there is an element of consultant drag. Self-paying patients do not face the same constraints as patients covered by PMI and in principle have more opportunity to determine both which consultant and which hospital to use (there are also one or two companies, for example Health Care Navigator, which have recently entered the market to provide specialist advice on the services offered by different hospitals and which offer the best value for money). In practice, however, self-pay patients also generally accept the consultant's choice of hospital and may also be subject to consultant drag effects.

4.25. Consultants undertaking private practice are essentially independent economic agents, in that they are not employed directly by either the private hospitals at which they treat patients or the PMI providers which pay most of their charges. They have also traditionally enjoyed considerable discretion over what specific medical treatment is required, where it should be provided and how, as well as the amount of their fees.

4.26. Over time, however, the major PMI providers, and BUPA in particular, have sought to influence consultants' behaviour in various ways. As referred to above, BUPA introduced its Benefit Maxima many years ago in order to contain insurance claim costs (and thereby premiums) by limiting the level of fees that it was willing to pay consultants for any given procedure. As indicated in paragraphs 4.31 to 4.39, the role and importance of BUPA's Benefit Maxima has increased during the 1990s following the withdrawal of the BMA's guidelines: the Benefit Maxima are now even more generally adhered to by consultants and PMI providers as a set of national benchmark prices.

4.27. More recently (within the last five years) BUPA has introduced two types of pre-authorization procedure, one essentially for the pre-verification by BUPA of appropriate insurance cover for a proposed treatment, and the second for authorization of a limited number of specified treatments. As regards the first type, BUPA subscribers have long been encouraged to contact BUPA before undergoing treatment so that BUPA can carry out eligibility checks (though this is not a condition of insurance cover). BUPA told us that it introduced a formal pre-authorization (or pre-verification) system in 1998 to deal with these matters, and to give a high level of reassurance to both its subscribers and the hospitals concerned. The checks applied include, among other things: whether the proposed hospital is BUPA-authorized and covered by the subscriber's policy; whether an appropriate scale of accommodation has been chosen (for example, B-band or C-band—see paragraph 4.80); whether the consultant chosen is a recognized specialist and BUPA-authorized (see paragraph 4.29), and whether the consultant is likely to charge within BUPA's Benefit Maxima scale of fees; and whether there are any policy exclusions (or claims excesses) which would render the claim ineligible.

4.28. As regards the second type of pre-authorization, BUPA first introduced a system of treatment (or clinical) pre-authorization for consultants in 1992. Initially, this related to psychiatric admissions only but BUPA extended the system in 1995 to cover intensive care, neurology and rehabilitation. Subsequently, it extended the system (in 1999) to include hysterectomy and wisdom teeth extraction. BUPA told us that its customers had welcomed these initiatives and it believed the introduction of pre-authorization may have helped to accelerate the adoption of better clinical practice. It added that it had been planning to further expand the scope of the system in the future to include common ENT procedures (such as tonsillectomy, adenoidectomy, myringotomy and ear grommets). But, following a series of discussions with ENT specialists, BUPA has recently decided not to extend pre-authorization to these ENT procedures, because the numbers of tonsillectomies etc now seemed to be declining dramatically. Pre-authorization (of the second type) has not been generally welcomed by consultants, however, and the BMA told us that it amounted to an unwarranted interference into the professional clinical judgement of consultants (see also paragraph 4.34 and Chapter 6).

4.29. BUPA also has a long-established system of authorizing consultants or granting BUPA recognition (in order to ensure high quality standards, BUPA told us); and only these consultants recognized by BUPA are permitted to deal with BUPA-insured patients.<sup>1</sup> For the most part, BUPA's recognition procedures involve checks on appropriate professional accreditation and that the applicant undertakes to maintain indemnity insurance. BUPA stated that it had no plans to move towards a restricted approved list of consultants to treat BUPA PMI subscribers; though it was seeking, in order to promote best practice, to develop specialist contracting with consultants in areas such as breast cancer and bone marrow/stem cell transplantation.

4.30. With respect to its recognition procedures for other medical specialists (for example, physiotherapists), where BUPA's Benefit Maxima do not apply, we note that BUPA's documentation may also include a requirement for BUPA to receive discounts off the level of fees charged to non-BUPA patients. BUPA told us that this related to a BUPA pilot scheme in the North-West of England in which physiotherapists were obliged to undergo a quality assurance process and to recontract their prices. According to BUPA, this pilot resulted in significant savings and BUPA planned to roll this arrangement out nationally.

4.31. In 1997, BUPA introduced its CPS. The principal objective of the CPS, BUPA told us, was to give customers the assurance that their consultants' fees would be fully covered, or to allow them to make an informed choice about whether or not to proceed with the treatment by a consultant who might bill in excess of BUPA's Benefit Maxima. Under this scheme, consultants were required to sign (or consent verbally to) what BUPA described as an 'informal agreement', the terms of which included a commitment to charge within the BUPA Benefit Maxima scale of fees, other than in exceptional cases. In return, BUPA undertook to provide a retrospective annual payment to consultants amounting to 5 per cent of the fee charged for each patient admitted to a hospital in BUPA's network. For patients admitted to non-network hospitals, BUPA undertook to reimburse at the Benefit Maxima in the normal way, ie without the 5 per cent bonus payment.

4.32. During the course of our inquiry and in response, BUPA told us, to critical feedback on the CPS from consultants, BUPA modified the terms of its CPS, with effect from 1 July 2000. Under BUPA's current CPS, there is still the requirement to charge within the BUPA Benefit Maxima scale of

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<sup>1</sup>We note that on the PMS side, BUPA PMS do not limit the granting of admission rights only to BUPA-recognized consultants, but apply their own checks on accreditation etc.

fees (other than in exceptional cases), but there is now no requirement for the consultant to use a hospital in BUPA's network. The annual, retrospective bonus payment has also been increased to 10 per cent of the BUPA Benefit Maxima fees. BUPA told us that the revised CPS was proving popular and that the number of consultants participating in it had grown from 5,600 in June of this year to nearly 6,250 in August.

4.33. BUPA estimated that the cost of CPS payments (made at the 5 per cent rate) over the 12-month period to the end of February 2000 had been £2.8 million, which it said was small in relation to BUPA's annual expenditure on consultant charges of about £260 million, and less than the cost would have been had BUPA increased its Benefit Maxima in line with the RPI over recent years. The Benefit Maxima fees were last revised on a comprehensive basis in 1994, though there have been some selected revisions since then.

4.34. In its evidence to us, the BMA said that the CPS amounted to an unwarranted interference into the professional activities and the clinical judgement and governance of consultants. The extra payments, it said, did not in any event cover all consultant services and were therefore less generous than appeared at first sight, and certainly a poor substitute for uprating BUPA's Benefit Maxima in line with increases in medical costs. The scheme in its original form also distorted the pattern of hospital use, it added, by potentially diverting both BUPA-insured patients not on network polices and other private patients towards BUPA network hospitals, including the BUPA-owned hospitals. The BMA took the view that the CPS was a reflection of BUPA exercising its market power in the PMI market to leverage adversely, but to BUPA's advantage, the downstream healthcare services sector (including both private hospitals and consultants). As a result, the BMA had actively sought to dissuade its consultant membership from joining the CPS. It also expressed concern that the proposed merger would further enhance BUPA's market power and thereby strengthen its ability to coerce consultants into joining the CPS.

4.35. We were told by several PMI providers (for example, PPP and Norwich Union) that in practice only 5 per cent or so of medical consultants regularly sought to charge in excess of BUPA's Benefit Maxima.<sup>1</sup> BUPA, on the other hand, provided data, summarized in Table 4.1, which suggested that the proportion was far higher. BUPA argued that the data showed that the CPS had been successful in protecting its customers' interests by substantially reducing the number of consultants charging more than the Benefit Maxima.

4.36. We note, however, that the percentage data are based on the numbers of consultants' bills rather than numbers of consultants. Nor do the data give any indication of (a) the magnitude of over- or under-charging relative to the Benefit Maxima and the amounts involved; and (b) the extent to which consultants who have joined the CPS have changed their charging behaviour: in principle, those that were charging at the Benefit Maxima anyway had most to gain from joining the CPS. Moreover, nearly [ 80 ] per cent of CPS consultants' bills continue to be for amounts greater than the Benefit Maxima. Consultants told us, however, that this reflected a tendency to charge above the relevant Benefit Maxima figure if the case was or turned out to be more than usually difficult or complex. Conversely, they tended to charge below the relevant Benefit Maxima if the case was simpler than average or expected: Table 4.1 indicates that nearly [ 80 ] per cent of consultants' bills to BUPA continue to be below BUPA's chargeable limits.

TABLE 4.1 Consultants' charges to BUPA in relation to BUPA's Benefit Maxima scale of consultants' reimbursable fees

	Consultants in the CPS	Consultants out- side the CPS	Total
Over maxima	[ Figures omitted. See note on page iv. ]		
At maxima			
Below maxima			

Source: BUPA.

<sup>1</sup>PPP also told us that it had a particular concern that BUPA's Benefit Maxima created distortions, because specialist consultants used the Benefit Maxima to increase their income by charging separately for individual elements of common procedures, or by charging by reference to more complex procedure codes than was warranted.

4.37. As mentioned, BUPA considered that the CPS has been successful and cost less than had the Benefit Maxima been increased in line with inflation. Indeed, BUPA appears to have maintained its Benefit Maxima at a constant level for several years, despite pressure for an upward revision from consultants.

4.38. The cost-effectiveness of the CPS is not clear-cut. Consultants who were already charging BUPA at or below the Benefit Maxima would have increased their fees by the amount of the retrospective bonus (previously 5 per cent and now 10 per cent). But, as mentioned in paragraph 4.36, nearly [ £100 ] consultants' bills to BUPA from CPS consultants were in excess of the Benefit Maxima. BUPA's estimate of £[ £100 ] million a year as the total cost was based on the 5 per cent rate and fewer consultants than are now in the CPS. At the 10 per cent rate and with more consultants, the current cost seems likely to be in the region of £[ £100 ] million to £[ £100 ] million a year.

4.39. It was put to us that consultants' charges to other PMI providers might as a consequence of the CPS tend to increase to match BUPA levels, thereby increasing costs to PMI providers as a whole. In turn, this would ultimately be reflected in higher costs to PMI policy-holders—and also possibly to self-paying patients. In addition, it was put to us that the CPS might tend to strengthen the existing links between BUPA and consultants: on average, BUPA currently accounts for around one-quarter of consultants' fee-based income from private work (and on average, a higher proportion of their income from insured patients). Although the CPS no longer includes the requirement to treat BUPA-insured patients at BUPA's network hospitals, it was put to us that the existence of BUPA's network and associated PMI policies, as well as the inconvenience to consultants of splitting their patient lists between different hospitals, was likely to encourage consultants to carry out more of their work at BUPA's network hospitals, ie there might continue to be an element of consultant drag.

## Market conditions and imperfections

4.40. Markets for healthcare services (principally PMI, PMS and consultant services) are characterized by circumstances and market imperfections which, in the view of many of those that gave evidence to us, are likely to inhibit the normal operation of market forces, and particularly the operation of price competition. The NHS, providing free services, alongside private healthcare (where all services must be paid for) may act as a constraint on the charges acceptable to those who can exercise a choice, particularly since both services use the same consultants (see paragraph 4.5) though the professional quality of the care should be the same. Within the private healthcare sector itself, some of the principal and systemic market imperfections (see also Laing & Buisson, Appendix 4.1, item 8) which are apparent include the following:

- (a) *The separation of payment from consumption.* PMI subscribers typically pay monthly premiums, but any private healthcare costs (excesses apart) are paid by the PMI providers (indeed, patients who are not liable for initial excesses are rarely shown either the hospital's bill or that for consultant services<sup>1</sup>), thereby insulating patients from the costs of their treatment. Moreover, some two-thirds of all PMI beneficiaries are covered by employer-paid policies, with the effect that they are almost totally insulated from decisions about, and costs of, treatment (although not from the tax on the taxable benefit element of the employer's policy).
- (b) *The sensitive nature of acute medical services (albeit elective) and the asymmetry of information between consumers and providers.* For the most part, patients are likely to be relatively ill-informed about their medical condition and any treatment that is required. As a result, they are largely reliant on the advice of GPs and consultants (who are not likely to have a direct interest in limiting treatment costs) with respect both to what treatment is needed and also which hospital to use.

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<sup>1</sup>The larger PMI providers (including BUPA, PPP, Standard Life and RSA) tend to settle hospital and consultant bills directly and consumers are not normally involved at all, other than for outpatient bills or where some part of the bill is not covered by the insured patient's policy (eg a policy excess). Indeed, under the terms of BUPA's Hospital Agreement Plan (HAP), hospitals have no need, BUPA told us, to provide BUPA-insured patients with details of hospital bills, and this was part of its strategy to improve customer experience, it said, by reducing the intrusive nature of the claiming process to a bare minimum. Some of the smaller PMI providers operate a more flexible policy on billing, and WPA even encourages its subscribers to negotiate self-pay rates with hospitals because it believes such rates to be lower than it would pay under its charging agreements with hospitals.

- (c) *Restrictions in supply.* As explained elsewhere (see paragraph 4.178), some acute private hospitals are solus operations in that they are effectively the only suitable private facility in a given local area, though in some cases their local market power may have been reduced somewhat in recent years as the number of NHS PPUs has increased. Consultants may also enjoy a degree of market power because of the limitations on their numbers, at least in the short term, and the current shortages of consultants in certain specialities.
- (d) *Limited price transparency and price rigidities.* Insurance products tend to be complex and difficult for consumers to compare in terms of value for money (see OFT, Appendix 4.1, items 3 to 6). Charges for private acute hospital services (see paragraph 4.140) are also complex and lacking in transparency, a difficulty which affects both PMI providers and self-paying patients, though in different ways. Consultants' fees are not subject to effective competitive pressures and in practice are closely aligned to BUPA's Benefit Maxima (see paragraphs 4.31 to 4.39), which therefore tend to act as a de facto national tariff of fees covering the full range of consultant services.

4.41. BUPA, on the other hand, said that although PMI and PMS markets exhibit a number of unusual characteristics they do not undermine the effectiveness of price competition. BUPA believed the PMI market was highly competitive and, as a result, PMI providers were driven to apply strong price pressures on both hospitals and consultants. Moreover, BUPA and others said that self-pay prices for PMS were transparent, and patients (or consultants, or their staff) could and did appraise different hospitals for the best value-for-money deal.

4.42. As regards other relevant market characteristics, entry conditions in respect of both PMI and PMS are considered separately in paragraphs 4.100 to 4.107 and 4.157 to 4.164, and vertical linkages, including those arising from the increased use by PMI providers of hospital networks and preferred provider arrangements, are considered in the next section.

### **Vertical linkages (ownership links/integration, preferred PMS providers, networks and other linkages)**

4.43. As explained in the section on market definition, we consider PMI, PMS and consultants' services to be separate economic markets. There are, however, linkages between each of them which are of special relevance to this inquiry, and which have either been introduced recently or have been strengthened in recent years. As regards PMI/PMS linkages, the only current instance of common ownership between PMI and PMS concerns BUPA, which has interests in both the PMI market (where it is the largest supplier) and the PMS market, where it is currently the second largest supplier. The proposed merger would strengthen the degree of common ownership by increasing BUPA's PMS market share from 15.3 to 22.4 per cent, measured in terms of bed capacity in private acute hospitals (including NHS PPUs). BUPA told us, however, that its PMI and PMS businesses operate at arm's length and entirely independently of each other, this relationship being reinforced by BUPA's internal Chinese walls (which are the subject of 'Confidentiality Guidelines').

4.44. BUPA's PMI business necessarily maintains close commercial contact with all of its authorized hospitals—including those actually owned by BUPA—and these contacts include the negotiation of hospital charges on an annual basis. Hospital charges, including the BUPA PMS charges to BUPA PMI, are considered in some detail in paragraphs 4.137 to 4.156. BUPA PMI is the largest customer of BUPA PMS (accounting for over [ 30 ] of all revenues from insured patients); and conversely, BUPA PMS is a major source of cost to BUPA PMI. In 1999, BUPA PMI incurred hospital cost expenditure of £[ 30 ] million with BUPA PMS, which amounted to [ 30 ] per cent of BUPA PMI's total such expenditure with all private acute hospitals (second only to GHG, which accounted for [ 30 ] per cent). [

*Details omitted. See note on page iv.*

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4.45. Other PMI/PMS linkages relate to the framework arrangements for business dealings between PMI providers and private acute hospitals. The main linkages of relevance include (a) hospital quality and cost assessment procedures; (b) hospital supply agreements (which include details of negotiated hospital charges); (c) arrangements for the pre-authorization of medical treatment; and, perhaps most importantly, (d) hospital network and preferred provider arrangements.

4.46. As regards hospital quality and cost assessment procedures, all PMI providers seek to ensure that the private hospitals they deal with are fully accredited and registered with the appropriate regulatory authorities. Most rely on appropriately worded ‘comfort’ letters from the hospitals concerned, in order to draw up approved lists. BUPA, however, undertakes a more detailed assessment of the range and quality of services provided by all the hospitals it deals with. It does this by requiring hospitals to complete a questionnaire: the Partnership Assessment Document or PAD. This covers organization, health and safety matters, clinical governance, nursing administration and general information. BUPA PMI uses this material to calculate a score for each hospital, indicating BUPA’s assessment of its overall quality. BUPA told us that thus far, only one network hospital—St Anthony’s (see Chapter 6)—had refused to go through BUPA’s PAD assessment process.

4.47. BUPA also compiles an Episode Cost Index (ECI) for all the hospitals that it deals with (including all hospitals on its approved list). The ECI is an indicator of overall cost, as measured by a weighted index of the charges levied by the hospital concerned. Both PAD scores and ECI ratings form part of the information base used by BUPA PMI in its annual negotiations with PMS providers about the level of hospital charges. It was put to us by third parties that (a) were BUPA PMI to get preferential terms from BUPA PMS, this would tend to deflate the overall average ECI (against which individual hospitals would be compared); and (b) these two assessments were neither undertaken nor audited by organizations which were independent of BUPA’s commercial interests. BUPA told us that it had offered to have the ECI calculations subjected to independent scrutiny, but that to date no PMS provider had taken up its offer.

4.48. With respect to hospital supply agreements, BUPA told us that the legal liability relationship was nominally between the individual patient and the hospital. But in practice PMI providers were responsible for payment in relation to over three-quarters (by value) of all private hospital charges. Reflecting this situation, all or most PMI providers have some form of supply agreement with the hospitals they deal with. Smaller PMI providers (for example, WPA and BCWA) usually rely on letters of understanding which set out the core areas of their commercially agreed arrangements, including charges and payment procedures. Both BUPA and PPP have more detailed agreement documents than other PMI providers (including Norwich Union, Standard Life and RSA).

4.49. BUPA’s HAP is the most comprehensive of all such agreements, including matters such as the procedures which BUPA recognizes, charging and payment arrangements, and the responsibilities of the hospital and of BUPA. We noted that the section of the HAP dealing with the ‘quality criteria and standards framework arrangements’ states that ‘the framework is intended as indicative rather than prescriptive, although BUPA considers that certain elements of the framework are mandatory’. The mandatory elements are not specified in the HAP but BUPA said that it used failings in the mandatory category to decide which hospitals it would inspect. Any hospitals judged by BUPA to have such failings were notified in writing, and reviewed at inspection before BUPA took any further action.

4.50. PMI provider arrangements for the pre-authorization of medical treatment (see also paragraph 4.27, where this area is dealt with in more detail, were introduced first by BUPA as a means, it said, of attempting to promote best medical practice and to benefit its customers by curtailing unnecessary treatments that resulted in unnecessary costs. BUPA told us that some other PMI providers were also starting to introduce their own pre-authorization measures. The BMA, and some hospitals (see Chapter 6), have raised critical objections to BUPA’s approach on the grounds of it being an unjustified interference in clinical judgement. We can see some justification in principle for pre-authorization procedures, and indeed claim assessment procedures are commonly deployed in other insurance markets as a check on bogus claims (which if met must raise the costs of insurance premiums to consumers as a whole). That said, however, BUPA’s pre-authorization scheme has not been widely welcomed by either consultants or hospitals. BUPA said that it was willing to share its conclusions on the impact of pre-authorization; but that to date it had not had any proposal to have the data independently audited.

4.51. Some third parties to this inquiry expressed concerns about various aspects of BUPA’s PAD, its ECI, its HAP and its pre-authorization procedures in the context of BUPA’s leading role in the PMI market (and also its common ownership links between PMI and PMS (see Chapter 6). Moreover, it has been put to us that these procedures confer on BUPA PMI considerable information about the operation of non-BUPA hospitals which are in competition with BUPA PMS, and that if this information were passed on to BUPA PMS, through a breach of BUPA’s Confidentiality Guidelines (see paragraph 4.43), it would be likely to put it at an unfair competitive advantage, relative to other PMS providers. Commenting on this, BUPA said that it was not aware of any evidence that breaches had occurred; and that it had invited hospitals to define what data were non-essential or commercially sensitive.

4.52. We consider PMI providers' hospital networks and preferred provider arrangements in more detail in paragraphs 4.108 to 4.121. The linkages between PMI providers and consultants, and most particularly the linkage established by BUPA's Consultant Partnership Scheme, were considered earlier in paragraphs 4.31 to 4.39.

## Market definition

4.53. In order to evaluate the effects of the proposed merger we need to consider which markets or areas of activity are of relevance, what products or services they include and also their geographic scope (local, national or international). In our view, there are three main areas that are of relevance to the proposed merger: PMI; PMS; and possibly the wider market for private healthcare (embracing PMI, PMS and consultant services). In our evaluation in this section, we apply where possible the normal tests of substitutability on both the demand and supply sides of the markets concerned.

4.54. An initial consideration is the role of the NHS, which is funded through general taxation but free at the point of service delivery, in contrast to paid-for private acute healthcare. Here, the conventional substitutability tests do not fully apply. Although there is supply-side substitution in relation to PUs and private acute hospitals (see paragraph 4.11), there is limited demand-side substitution, because many people cannot afford private treatment and taxpayers are not in any event able to opt out of paying for the NHS. Moreover, although elective treatment for acute medical conditions is available from both the NHS and private healthcare, the latter offers additional, and valued, services in terms of higher standards of hospital accommodation, greater choice of consultant, and earlier treatment. We take the view, therefore, that although the NHS provides an element of price constraint, the willingness of consumers to pay an extra charge for private acute healthcare is an indication of this being a different market from that of the NHS. None of the parties that gave evidence to us during this inquiry suggested otherwise.

4.55. PMI policies provide indemnity cover against the costs of private medical treatment, and are well established in the UK (and elsewhere). As explained in paragraphs 4.79 to 4.89, although the terms and conditions of PMI cover vary widely, the main policy features relate to the comprehensiveness of treatment covered, and whether the policy-holder's choice of hospital is unrestricted, or alternatively limited to a specified network of hospitals, or preferred providers (see paragraphs 4.108 to 4.121). PMI policies for personal subscribers are largely standardized products, whilst those for the larger corporate users are adapted to the purpose. Within the personal sector, all such policies are readily substitutable<sup>1</sup> and, as agreed by all those that gave evidence to us, fall within the same market. Although there are differences in policy products as between the personal and corporate sectors (especially with respect to large companies), there is a high degree of substitutability on the supply side, and for that reason we consider, and all parties agreed, that these form part of the same economic market.

4.56. PMI offers full or at least wide-ranging indemnity cover, but there are various other insurance products available which provide partial cover only. Health cash plans, for example, offer limited cash payments to subscribers to partially compensate for a temporary loss of income; or to partially offset the costs of an overnight stay in a private hospital; or for primary care medical treatment. Reflecting their limited cover against medical costs, such products are relatively inexpensive compared with PMI,<sup>2</sup> and in practice many people take out both PMI and cash plans (see Laing & Buisson, Appendix 4.1, item 8). Some PMI providers (for example, BUPA, PPP, Norwich Union and Standard Life) have recently started to offer cash plans, but much the largest suppliers are contributory schemes run on a not-for-profit basis by bodies such as The Hospital Saving Association. For these reasons, we consider health cash plans to be complementary to PMI rather than substitutes for it.

4.57. Similarly, critical illness cover, dental benefit plans and income protection insurance also offer products which relate to at least some elements of private acute healthcare, and might therefore be considered as economic substitutes for PMI. Critical illness insurance (total subscription revenue of £1.8 billion in 1999), for example, offers a lump-sum cash payment when the subscriber is diagnosed as having a defined critical illness condition (for example, cancer) for which the long-term incapacitating

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<sup>1</sup>As explained in paragraph 4.84, subscribers with pre-existing medical conditions tend to be locked in to their existing PMI provider because of moratorium conditions, or the extra costs of coverage involved, thereby limiting their ability to switch between alternative PMI providers.

<sup>2</sup>In 1999, the average annual cost per subscriber for cash plans was just over £100 (total subscription revenue was about £330 million), compared with just over £1,000 for personal PMI subscribers. Unlike PMI, most people covered by cash plans are personal subscribers, rather than being covered through company schemes.

effects are not normally covered by PMI. The vast majority of such policies (over 85 per cent) are taken out by individuals as a supplement to existing life assurance or mortgage protection policies. Income protection insurance (total subscription revenue of £625 million in 1999, half of which derived from company schemes) provides a regular income in the event of subscribers being too ill to work. Most of the suppliers of both critical illness and income protection insurance are general insurers (for example, Legal & General, Lloyds and Allied Dunbar), and some are also PMI providers (for example, AXA/PPP, CGNU/Norwich Union, RSA and Standard Life). As regards dental benefit plans (total subscription revenue of £240 million in 1999), the cover provided relates to dental treatment only (routine dental treatment is not usually covered by PMI policies); and all the main PMI providers also offer such plans in one form or another.

4.58. As with cash plans, these types of insurance appear to us to be essentially complements to PMI rather than substitutes: for the most part, they do not cover PMS; and, apart from dental insurance, the main suppliers are other than the PMI providers. Neither BUPA<sup>1</sup> nor CHG nor most of those who gave evidence to us suggested that these various insurance products (cash plans, critical illness cover, income protection policies and dental cover) should be included as part of the relevant market alongside PMI products. Accordingly, we have concluded that for the purposes of this inquiry these various other insurance products should not be taken as part of the same market as PMI.

4.59. The use of TPAs might also be considered, for the larger companies at least, to be an economic substitute for PMI; and hence it might be thought that such business (which has grown in recent years) should be included as part of the relevant market. Medisure (the largest TPA in the UK) told us, for example, that it carried out many of the same functions as PMI providers (writing policies, negotiating with hospitals with regard to charges, networks and preferred provider arrangements, and claims administration, including payment for treatment received, etc) though it did not underwrite or bear any risk itself. Indeed, this was undertaken largely by the other major PMI providers (BUPA and PPP, in particular, and also Norwich Union until recently). Nonetheless, Medisure told us that it competed directly with the PMI providers for large corporate business. TPA operators are described in paragraph 4.95.

4.60. Parties to this inquiry had mixed views about whether use of TPAs was part of the PMI market, but we consider that it should be included because TPAs' functions largely mirror those of PMI providers; and, for the larger companies at least, TPAs appear to be an economic substitute for PMI. In practice, there are difficulties in separately measuring the value of TPA business, but it appears to account for less than 5 per cent of PMI revenues as a whole.

4.61. A parallel argument applies to whether or not self-paying patients should be considered to be part of the PMI market, because they would appear to have a choice between buying PMI or self-insuring, in the sense of either establishing a separate savings fund for future medical expenses, or simply paying for any such treatment costs as they arise. For some self-payers this may be valid, though the evidence available (see the ABI study, Appendix 4.1, item 12) suggests that they tend to be in markedly higher age ranges than PMI subscribers. This may reflect the much higher costs of PMI for such age groups; and many may also be retired people who were previously covered by company schemes and who have become accustomed to private treatment. BUPA also told us that a more limited range of treatments was carried out on a self-pay basis than under PMI. Moreover, PMI is a clearly identifiable insurance product. In that context, self-payers are simply choosing not to buy this product and its risk-pooling characteristics or advantages; and for the most part, the only economic transaction involved is that between self-payers and PMS providers: no third parties are involved, as is the case with TPA business. Taking account of these factors, we see self-pay as part of the PMS market rather than PMI, and most of those who gave evidence to us did not suggest otherwise.

4.62. As regards the geographical scope of the market, all the major PMI providers operate on a nationwide basis, ie their PMI products are available to consumers throughout the UK, they are priced largely (albeit not wholly) on the basis of standard national tariffs, and indeed PMI premium charges largely reflect private hospital treatment and consultant costs which are themselves predominantly set on an average national basis (see paragraph 4.138). Moreover, there is virtually no inter-country trade in PMI products, although (a) some PMI providers in the UK are foreign-owned, for example PPP/AXA; and (b) some PMI business involves insurance cover for UK nationals working abroad. We therefore consider that the market for PMI is national; none of the parties to this inquiry suggested otherwise.

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<sup>1</sup>BUPA said that cash plans etc could be regarded as being part of the same market for funding healthcare needs, but accepted that pragmatically it would be difficult to collate and consider all the appropriate market data.

4.63. Turning to private medical treatment services, there are also several matters to consider in determining the relevant market. First, there is the question of whether PMS and services provided by consultants form part of the same market. Clearly, the two are closely interrelated in all treatment episodes. But consultants provide different, specialist medical services; they are independent of hospitals, both contractually and in terms of employment; and the two parties offer self-evidently complementary rather than substitute products in an economic sense. We therefore consider that they are in separate economic markets.

4.64. Second, there is the question of which types of private hospitals and accommodation facilities should be included. Acute hospitals provide a wide spectrum of treatment services which accord closely with the range of treatments covered by PMI. All the hospitals owned by BUPA and CHG are of this type: they are central to this inquiry. Other private hospitals and clinics, however, are more specialized and typically deal with single types of procedure or treatment, most of which are not normally covered by PMI, nor are they dealt with by most private acute hospitals to any great extent: these include pregnancy termination, cosmetic surgery and psychiatry. As in the 1990 inquiry, therefore, we consider this latter group of hospitals to be in separate markets from that relating to private acute hospitals and the services that they provide.

4.65. We need also, however, to consider the PPU's and NHS pay-beds. The PPU's are broadly similar in many respects to private acute hospitals and we consider, as did BUPA, CHG and others, that they both operate broadly within the same market. NHS pay-beds on normal NHS wards (about 3,000 in total) are more problematic, however. BUPA suggested that (following the approach taken in the 1990 report; see Appendix 4.1, item 1) around 10 per cent of these beds should be included in our quantitative assessment of market shares. However, we do not consider NHS pay-beds to be substitutes for either PPU's or private acute hospitals, and have therefore excluded them from our analysis. In practice, this does not greatly affect the calculation of market shares (see paragraph 4.124).

4.66. Taking private acute hospitals and the services they provide as the relevant product market (which we refer to throughout this report as PMS), we need also to consider the question of geographic scope. Here there are both local and national market influences. At the local level, most patients (whether insured or self-pay) do not travel far for their treatment;<sup>1</sup> and similarly consultants normally seek admission rights at private acute hospitals that are not too far from the NHS Trust hospital where they are based (so that private acute hospitals in the same area compete with each other to attract consultants to use their facilities). Thus there appears to be a series of geographically local markets (or catchment areas), many of which are likely to overlap to varying degrees. Hence the extent of local market competition between private acute hospitals within the same catchment area is of close relevance to this inquiry, as indeed is evident from the concern expressed by the DGFT, which led to the reference to us.

4.67. We consider in more detail later (see paragraphs 4.165 to 4.190) how to evaluate local markets and areas of overlap between hospitals. But we note here that the relevant market for an individual hospital may be wider in some cases than in others. Thus where patients require specialist treatments and associated facilities that may not be generally available, for example, those for complex heart surgery or cancer care, they may need to travel further afield. Additionally, contiguous local markets may together form a wider geographic market.

4.68. Moreover, market conditions in the London region differ markedly from those prevailing elsewhere in the UK. Many of the main NHS teaching hospitals are located in London and enjoy the services of eminent consultants, who also undertake private work at well-known central London private acute hospitals, such as The Harley Street Clinic and The Wellington Hospital. We were told also that the London PPU's, partly reflecting their links with the teaching hospitals, appear to be a more effective competitive force than in other parts of the country. As noted earlier, there is a higher proportion of self-paying patients in London (including many from overseas), and travelling conditions are also different. Additionally, the private acute hospitals of the four national PMS providers are (save for three owned by GHG) all outside London. By contrast, HCA(London), which is the fifth largest PMS provider by capacity, but the fourth largest by revenue share, operates entirely within London. These special features, together with the much higher density of population, suggest that London should be regarded as a distinct market segment in itself.

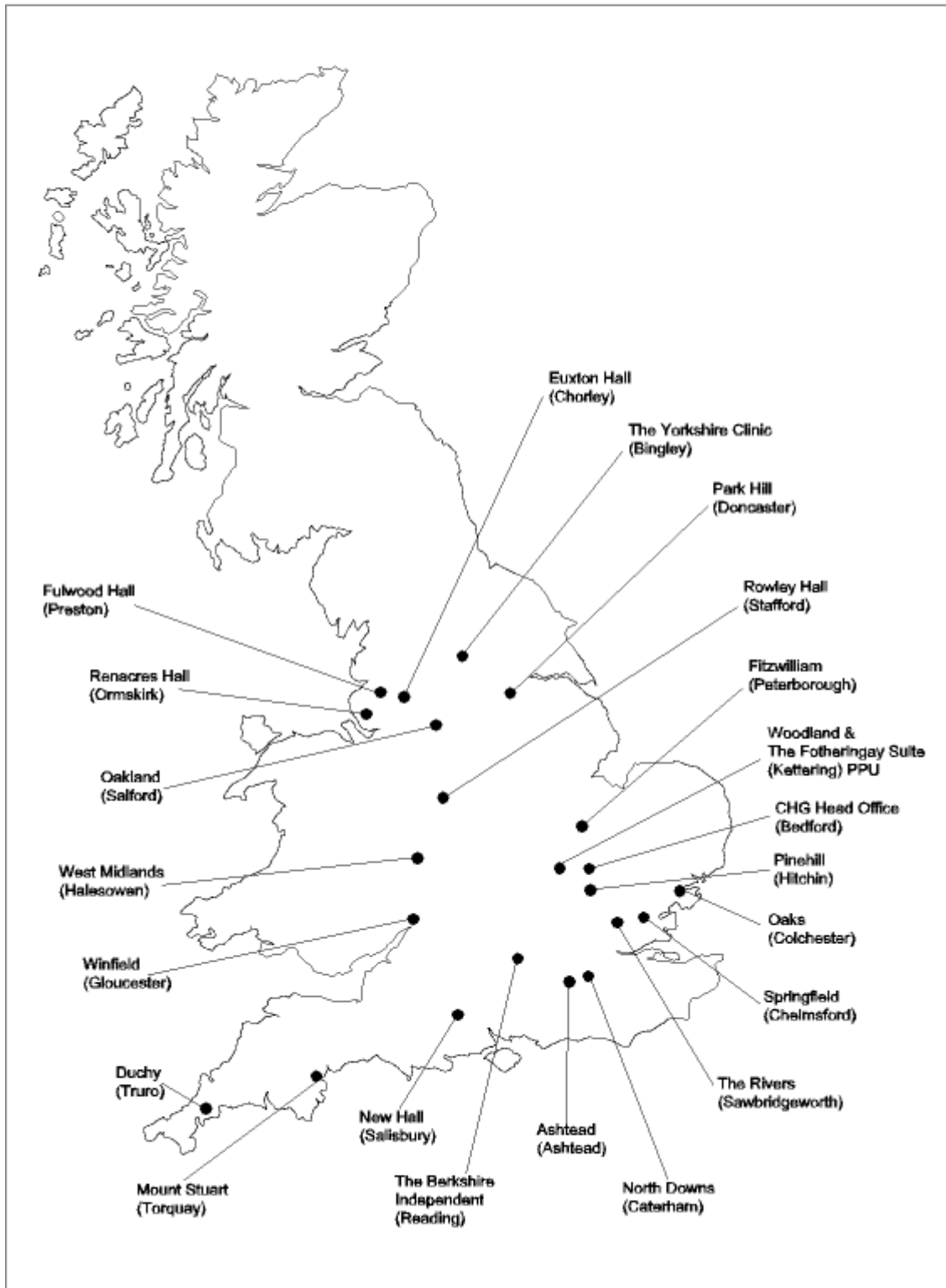
4.69. But there are also some strong national influences on the PMS market. In particular, each of the four national PMS providers, which together account for more than one-half of all private acute

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<sup>1</sup>As indicated by most parties to this inquiry, as well as patient surveys and hospital discharge data (see paragraph 4.173).

FIGURE 4.1

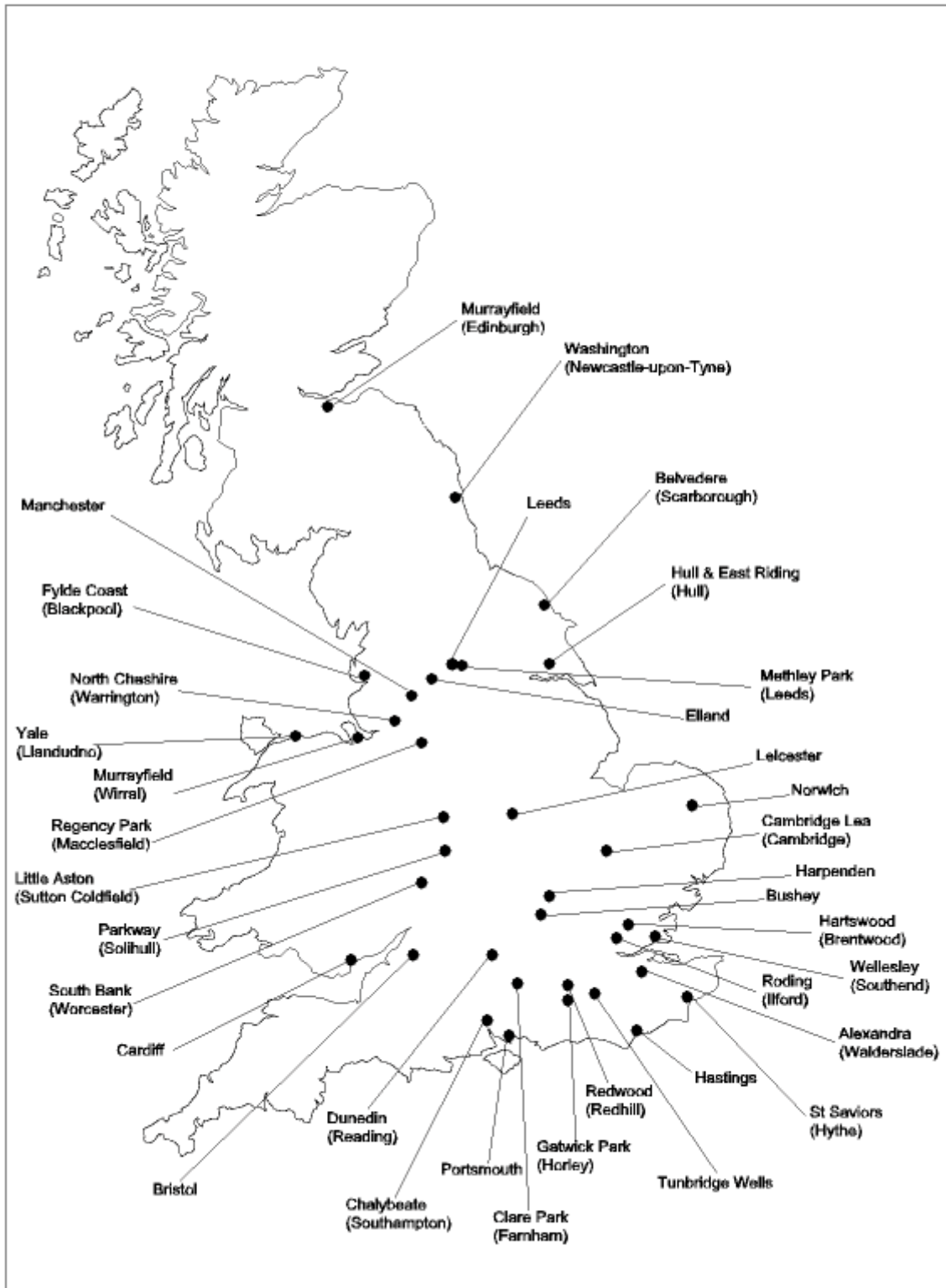
**CHG hospitals and PPUs**



Source: CHG.

FIGURE 4.2

**BUPA hospitals**



Source: BUPA.

hospital capacity (and a greater proportion of capacity outside London), have hospitals which are widely distributed across the country, although typically clustered around the main centres of population. The geographic distribution of CHG's hospitals (the smallest of the four national PMS providers) is given in Figure 4.1 and that for BUPA in Figure 4.2.

4.70. Of equal importance is that some 80 per cent or so of patients in private acute hospitals are insured by PMI providers who themselves operate on a national basis. To provide national coverage to their subscribers these providers need to have supply arrangements or agreements (whether formal or not) with hospitals up and down the whole country. Indeed, PMI providers typically negotiate price terms with the largest on a national average basis (see paragraph 4.138). Hence, hospital pricing is largely determined on a national basis, rather than directly reflecting local market conditions (for example, the local cost base) or the strength or weakness of local market competition. Some private acute hospitals face no local competition and are said to be solus operators (see paragraph 4.40). As explained in paragraph 4.40, however, it has been put to us that there might be important indirect effects in that PMS provider groups are in a stronger bargaining position vis-à-vis PMI providers the more solus hospitals and prestigious flagship hospitals they own.

4.71. Additionally, some of the main PMI providers (including BUPA, PPP and Norwich Union) have established national networks of hospitals (see paragraphs 4.108 to 4.121), where the hospitals agree extra discounts to the PMI providers for being included in their networks. Hospital charges (the extra discounts) are agreed on a national basis for the hospital chains, but competition for admission to the networks includes local and national elements.

4.72. As a consequence, we have concluded that competition and the effects of the proposed merger within PMS markets need to be considered at both the local and national levels, with London being a distinct market segment in itself.

4.73. Turning now to the question of whether there is a wider market comprising PMI (including TPA business), PMS and even perhaps consultants' services, we start by noting that (a) these are interdependent service markets, rather than a series of normal consumer product markets where there is an upstream/downstream supply chain from production, through wholesaling to retail distribution; and (b) there are several vertical linkages between PMI, PMS and consultants (see paragraph 4.43). But for these services collectively to be considered as a single, unified economic market they would need to be seen as economic substitutes, which consumers might reasonably be expected to switch between in response to price signals. In effect, this line of reasoning is similar to the argument that self-pay is part of the PMI market, rather than simply an element of PMS revenues. As indicated above, we do not accept that argument, because of the differences in demand characteristics. Moreover, we regard PMI (including TPA business), PMS and consultants' services as separate and complementary groups of products and markets. For the purpose of this inquiry, therefore, we do not consider that PMI, PMS and consultants' services should be taken as a unified and distinct economic market.

## **PMI market**

4.74. PMI provides indemnity cover against the costs of private medical treatment (examinations, surgery and other medical treatment), whether in consulting rooms or in private acute hospital treatment facilities, including in many cases the PPU's operated by NHS Trusts. Individual PMI subscribers usually cover not only themselves but also other family members.

4.75. Subscribers to PMI include both private individuals (the personal sector), and companies (the corporate sector) buying cover for their employees. Within the personal sector, we were told that PMI cover was something of a luxury good, in the sense that it was relatively high-cost and arguably non-essential, with the NHS offering an alternative service which is free at the point of delivery. The majority of subscribers are within the ABC1 socio-economic groups, and are commonly middle-aged professionals and managers. There is also a strong regional subscription bias towards London and the South-East of England. According to Laing & Buisson (Appendix 4.1, item 8) and others, aggregate demand is relatively unresponsive to price signals, but sensitive to income levels (ie it is price inelastic, but income elastic). We note, however, that in response to the large increases in the costs of PMI premiums in the late 1990s, many subscribers appear to have adopted less costly policy options. BUPA told us that many elderly subscribers appeared to have left the market since the removal of tax relief for the over-60s; but PPP stated that its view was that demand for PMI was price elastic.

4.76. PMI corporate schemes include arrangements for smaller companies that are broadly similar to those for private individuals; and bulk schemes for larger companies that are often adapted to their specific requirements, and at subscription rates that reflect their past claims experience (ie experience-related policies). In addition, companies and other organizations may negotiate special discount arrangements with PMI providers under which their employees can subscribe on an individual basis. According to Laing & Buisson, corporate demand for PMI is marginally more responsive to price signals than the personal sector (albeit still price inelastic), and the age profile of those covered is younger. BUPA told us that PMI provider shares in the larger company market segment could change markedly in response to small changes in price.

4.77. Laing & Buisson estimated that in 1999 there were nearly 3.5 million subscribers in total in the UK, with the total number of persons covered being 6.4 million (about 10.8 per cent of the population). Of those, around two-thirds were covered under company-paid policies, and one-third of subscribers (and persons covered) were private individuals. In revenue terms, however, the balance is reversed, with the personal sector accounting for nearly 60 per cent of subscription revenues, and the corporate sector for the other 40 per cent or so (see Datamonitor, Appendix 4.1, item 10).

4.78. Additionally, some large companies choose to cover the costs of their employees' private medical needs directly (or by setting up a trust fund, which has tax advantages) rather than through PMI. They may, for example, simply process any claims themselves and pay the expenses directly; they may in some cases use their own associate insurance company; or they may use a TPA to undertake the administration work, including the authentication of claims and any costs incurred. Around 250,000 employees (and 650,000 persons in total) are covered by such arrangements—nearly 10 per cent of the corporate segment.

### ***Policies, prices, networks and competition***

4.79. Across all PMI providers there is a wide variety of PMI products or policies available, offering various types and degrees of insurance cover at different prices. The main elements of such policies, however, are the range and comprehensiveness of treatments covered; the freedom of choice with regard to hospital usage; whether or not there are cost excesses; and subscriber risk profiles. Indeed, within the personal sector, where policies tend to be more standardized than in the corporate sector, the two main features are (a) whether the treatment cover is comprehensive or limited; and (b) whether the policy offers a choice of all suitable hospitals, or of a restricted network. In 1999, BUPA's four main policy schemes,<sup>1</sup> for example, were:

- (a) *BUPACare*: fully comprehensive and offering a virtually unrestricted choice of hospital within BUPA's approved list (see paragraph 4.46);
- (b) *EssentialCare*: offers reduced outpatient cover (for example, not fully comprehensive), but as with *BUPACare*, this scheme allows the policy-holder a virtually unrestricted choice of hospital;
- (c) *LocalCare*: fully comprehensive, but policy-holders must use one of BUPA's network hospitals for inpatient treatment (ie a restricted choice of hospital—see paragraphs 4.108 to 4.121); and
- (d) *LocalHospitalCare*: offers reduced outpatient cover (ie not fully comprehensive), and as with *LocalCare*, policy-holders are restricted to using one of BUPA's network hospitals.

4.80. As would be expected, premium costs are highest for the fully comprehensive policies and where the choice of hospital is least restricted. Some BUPA non-network policies (for example, *BUPACare*) also have different levels of hospital accommodation cover according to the premium paid, designated as A-band, B-band or C-band. These relate essentially to the standard and cost of hospital

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<sup>1</sup>During the course of our inquiry, at the end of September 2000, BUPA announced that it would be discontinuing these policies for new business (apart from *LocalHospitalCare*, which would continue to be available), and introducing a more flexible policy package called *BUPA Heartbeat*, which was tailored to individual requirements and risk profiles, and enable more pre-existing conditions to be covered.

accommodation, with A-band corresponding to the highest standard (and also highest cost) available, B-band to the next highest, and C-band the lowest. Most private acute hospitals authorized for use by BUPA subscribers offer a mixture of B-band and C-band levels of accommodation; and most PMI policies relate to a C-band level of accommodation.

4.81. BUPA's network policies were first introduced in the mid-1990s as a means of offering a lower-priced product (see also paragraphs 4.108 to 4.121). Currently, the monthly premium charges for BUPA's network policies are around 6 to 8 per cent less than for non-network equivalents (in terms of healthcare cover). BUPA's hospital network includes 165 private acute hospitals within the UK, and comprises all the BUPA-owned hospitals and all or most of those owned by GHG, Nuffield and CHG, but does not include PPUs. Around 40 per cent of BUPA's subscribers (both personal policy-holders and those covered under corporate schemes) currently hold network policies.

4.82. PPP and Norwich Union, but not the other PMI providers, have also introduced network-type products. Indeed, more than 90 per cent of PPP's subscribers (both personal policy-holders and those covered under corporate schemes) are covered by such policies. PPP's network (158 hospitals and 45 PPUs—see paragraph 4.112) was formed as a result of a competitive tendering exercise undertaken by PPP in each local market. The number of hospitals included in each of the main PMI provider networks are given in Table 4.3; and the implications for hospital charges are considered in paragraphs 4.137 to 4.156.

4.83. The cost to subscribers of monthly PMI premiums (the usual form of payment arrangement in this market) is also affected by whether or not claims excesses apply. Each of BUPA's policies listed above, for example, has five excess options from £100 to £500.<sup>1</sup> A more important and indeed main determinant of relative premium costs, under BUPA policies and those of all other PMI providers, is the age of the subscriber: costs are markedly higher for older subscribers. Nonetheless, Medisure told us that the PMI price differentials were distorted and that, in terms of risk, older subscribers were effectively subsidized by younger subscribers.

4.84. Premium costs do not necessarily increase following a claim for treatment (ie there is no widespread equivalent to a loss of no-claims bonus, as applies with motor insurance policies). However, under BUPA's policies and also those of most other PMI providers, a new subscriber might not be granted cover at all for some pre-existing conditions; or more typically, such cover would only be granted after the policy had been operational for a period of two years, without there having been a claim in relation to such pre-existing conditions. In the PMI industry these are termed moratorium conditions. As a result, policy-holders who have made claims for treatment in the past have a strong incentive to stay with their existing PMI provider rather than to switch to another insurer. Subscribers who have made claims, however, are able to switch between the different policies offered by their existing PMI provider without incurring a cost penalty.

4.85. As mentioned above, PMI premiums, for all PMI providers, are typically paid monthly, though the level of premiums are reviewed by each PMI provider on an annual basis in the light of aggregate claims against the PMI provider in the previous year. In 1999, personal subscribers on average paid PMI rates of around £90 a month (just over £1,000 on an annual basis) to cover themselves and their families. Subscription rates, again for all PMI providers, have been rising at roughly twice the rate of general inflation (the RPI) in recent years, reflecting the upward trend in the frequency of claims. BUPA told us that claims frequency was driven in turn by changes in medical technology, changes in consumer behaviour and the periodic changes in the performance of the NHS.

4.86. As regards competition in the personal sector, consumers undoubtedly enjoy a wide choice of policies and PMI providers (see paragraph 4.90et seq). However, both the policies themselves and the price terms involved are complex in nature and it is difficult for prospective subscribers to compare different products in respect of value for money. We note that the OFT (see Appendix 4.1, items 3 to 6) has had concerns about the quality of policy information made available by PMI providers. We also noted the providers' efforts in recent years to effect improvements. A particular problem has been the

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<sup>1</sup>That is, a £100 excess means that the policy-holder undertakes to pay the first £100 of the claim costs relating to each year of cover.

continuous rise in PMI premium costs. Despite widespread press coverage on this, we were told that many new or potential subscribers appear to be unaware that premium costs could continue to rise in the future, and have little way of knowing whether the premium costs of one PMI provider are likely to rise more or less than another (though fixed-price policies are also now becoming available, from BUPA and others, partly in recognition of this difficulty). As explained above (paragraph 4.84), existing subscribers also tend to become locked in to their particular PMI provider and do not readily switch from one to another.

4.87. Turning to the corporate sector, small company schemes tend to be similar to those for private individuals, albeit rather more flexible and experience-related to some degree. PMI products for larger companies, covering hundreds and in a few cases thousands of employees, are often adapted to meet their specific requirements and are provided at subscription rates that reflect past claims experience (ie experience-related policies). Some large company policies operate under preferred provider arrangements which are similar to networks (see paragraphs 4.108 to 4.121), in so far as they limit the number of hospitals which may be used.

4.88. Whilst the PMI products in the corporate sector may be at least as complex as those in the personal sector (and possibly more so), an important difference is that companies have greater resources to undertake value-for-money comparisons between competing products and PMI providers. Moreover, companies often use insurance brokers or intermediaries to carry out such comparisons and to seek the best options available: according to Laing & Buisson (see Appendix 4.1, item 8), such intermediaries account for around 60 per cent of sales to corporate customers (compared with 10 per cent or so in the personal sector). Such activity is further aided by the fact that in principle companies are more able (and willing) than individuals to switch their business from one PMI provider to another where rates change or where a better value option has been identified.<sup>1</sup> An added advantage for companies is that, as mentioned earlier, they have the option of covering their employees' private medical costs directly rather than taking out insurance; and also of using a TPA to undertake the necessary claims administration.

4.89. As a result, competition between PMI providers for corporate business is generally considered to be active, and also effective in driving subscription costs down. We note that the costs per subscriber in 1999 were just under £500 a year compared with just over £1,000 a year for personal subscribers (and PMI providers' gross profit margins are one-third lower on corporate business), though the difference reflects many factors apart from competition effects. Most particularly, the age and risk profiles of the two populations (corporate employees and personal subscribers) are likely to be very different, with employees generally being much younger; there is a risk-pooling effect with any sizeable group of individuals; and PMI providers also achieve marketing and administrative cost savings when insuring a group rather than an individual. According to Laing & Buisson and some of the PMI providers who gave evidence to us, there is also an element of strategic price discounting by PMI providers in the corporate sector, ie pricing at or below economic costs in order to win or retain corporate business. Indeed, Medisure claimed that some PMI providers cross-subsidized their low-margin corporate business from their relatively higher-margin personal sector business.

### ***Sales, PMI providers and market shares***

4.90. As indicated earlier (see paragraph 4.75), aggregate demand for PMI is price inelastic, though fairly income elastic. As a result, fluctuations in overall demand have been broadly pro-cyclical, though other factors have also been important. During the 1980s, the total number of subscribers doubled to about 3.3 million. In part, this expansion reflected income growth, but in addition there were increasing concerns about NHS waiting lists; and the Government of the day also introduced measures aimed at promoting the development of PMI, PMS and private healthcare in general.

4.91. Since 1990, however, the growth in subscriber numbers has been far more limited, as shown in Table 4.1. Although demand in the personal sector expanded in the early 1990s, the ending of tax relief on PMI premiums for the over-60s in 1997 and the imposition of IPT, have contributed to a reduction in

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<sup>1</sup>Medisure told us, however, that in practice there were considerable costs and difficulties for companies in switching between either PMI providers or from a PMI provider to a TPA arrangement. Companies would therefore normally stay with a PMI provider or TPA for two to three years before considering switching to a rival provider.

numbers in each of the last three years; and they are now nearly 9 per cent down on the peak year of 1996. There has been some offsetting growth in corporate sector subscribers, however, with the result that the total number of subscribers increased by about 5 per cent overall during the 1990s.

4.92. In revenue terms, on the other hand, there has been substantial growth in both nominal and real terms over this period, with total subscription revenues doubling to £2.3 billion in 1999. As is self-evident given the slow growth in PMI subscriber numbers, this doubling very largely reflects increases in the cost of PMI premiums, which itself will have at least constrained potential growth in the number of subscribers. Many subscribers, we understand, have also switched their policy cover from comprehensive to network and other budget policies, in response to the increase in premium costs.

4.93. As regards the PMI providers, they include—somewhat unusually—both not-for-profit and provident-type organizations (see Table 4.2), and commercial insurers. During the 1990s there were several new entrants (all commercial insurers), a series of mergers and amalgamations among the PMI providers, and several exits from the market. In the early 1990s perhaps the most notable new entry was that by Norwich Union (a commercial insurer, now part of CGNU), which started up de novo rather than by acquiring an existing provider. Norwich Union told us that through heavy investment it rapidly gained a market share of 5 to 7 per cent, though its growth slowed in the latter part of the decade. Standard Life (also a commercial insurer, though ultimately owned by a provident-type mutual organization) entered the market in 1994 by acquiring Prime Health, which had itself grown rapidly over the previous five years. Other entrants in the early to mid-1990s included Abbey Life, Eagle Star, Guardian, Gerling and Cornhill Insurance (all general commercial insurers), though each of these has now left the PMI market. Allied Dunbar, OHRA and Strasbourgeoise also entered the market during this period (see Laing & Buisson, Appendix 4.1, item 8).

TABLE 4.2 Sales value of PMI subscriptions in the UK, PMI providers' market shares\* by sales value, measures of concentration, and PMI subscriber numbers, in 1990, and 1995 to 1999

	1990	1995	1996	1997	1998	1999
Annual value (£m)	1,112	1,767	1,931	2,120	2,182	2,317
<i>Market shares (%):</i>						
BUPA	49.6	44.1	42.1	40.9	39.9	40.1
PPP (AXA)	28.4	26.9	27.2	27.8	31.5	29.1
Norwich Union	0.0	7.4	7.5	7.1	7.1	7.6
Standard Life/Prime Health	0.3	3.8	5.2	5.4	5.8	6.0
RSA	3.1	2.0	2.0	2.5	3.0	4.4
WPA	6.6	5.0	4.9	4.5	4.4	4.6
BCWA	2.5	2.1	1.9	1.8	1.9	2.0
Other provident insurers†	1.8	1.8	2.0	2.0	2.0	2.4
Other commercial insurers‡	7.8	6.9	7.2	7.9	4.0	3.8
Total	100.0	100.0	100.0	100.0	100.0	100.0
<i>Total number of subscribers</i>						
(‘000)	3,296	3,366	3,392	3,424	3,512	3,472
<i>Of which:</i>						
Corporate	1,984	1,972	1,962	2,054	2,186	2,213
Personal	1,312	1,394	1,430	1,370	1,326	1,259
<i>Concentration measures</i>						
CR4§	87.6	83.5	82.0	81.3	84.3	82.8
HHI¶	3,940	3,265	3,160	3,195	2,915	2,765

Source: CC, based on information from PMI providers and Laing & Buisson.

\*PMI providers are ranked by market share in 1999. Sales values are given in ‘cash of the year’ terms, unadjusted for inflation. Figures for BUPA, PPP and Norwich Union include some elements of TPA business, though TPA is otherwise excluded because of lack of data.

†Includes CS Healthcare, Exeter Friendly Society, Manor House Healthcare, Private Patients and Provincial Hospital Services Association.

‡Includes Abbey National, Abbey Life, Allied Dunbar, Cigna Healthcare, Legal and General, OHRA, Permanent Health, QBE International (now Groupama) and Strasbourgeoise.

§CR4 is the four-firm concentration ratio, ie the sum of the market shares of the four largest suppliers in each year.

¶Hirschman-Herfindahl Index, more commonly known as the Herfindahl Index, calculated as the sum of squared market shares for all suppliers, ie PMI providers in this case.

4.94. In the late 1990s the main new entrant was Abbey National—a commercial bank which had previously been a building society—and which since late 1997 has operated a joint venture with Norwich Union (which sets up policy schemes on behalf of Abbey National, administers claims and coordinates relationships with hospitals and consultants, ie it provides TPA services to Abbey National). In 1999/2000, QBE International, an Australian commercial insurer, entered the market by acquiring both Reliance and Iron Trades, but this business was subsequently sold to Groupama.

4.95. In the TPA sector (with a total annual value of around £100 million and which we include as part of the overall PMI market—see paragraph 4.60), the largest operators are Medisure and Remedi, but others include Executive Healthcare, Buck & Willis and IPH Insurance Services. BUPA and PPP also undertake TPA business both directly and indirectly, through underwriting some of the risks for other TPA operators (though most such underwriting is done through Lloyds).

4.96. Table 4.2 shows, for 1990 and 1995 through to 1999, the sales value of PMI subscriptions (but largely excluding TPA), PMI providers' market shares, numbers of subscribers, and two measures of market concentration. As shown in the table, the two largest PMI providers by far are BUPA PMI (which has a market share of about 40 per cent;<sup>1</sup> see also Chapter 3) and PPP (with a 29 per cent share). BUPA has for many years been the leading supplier of PMI in the UK, and is the only one that has both PMI and PMS interests.<sup>2</sup> In 1990, BUPA PMI accounted for half the PMI market, but this share was eroded during the first half of the decade with the entry of Norwich Union and other commercial insurers. Over the past three years (1997 to 1999—see Table 4.1), BUPA PMI's share has been stable at about 40 per cent.

4.97. PPP, which had previously been a provident-type organization but is now a commercial insurer, was acquired by Guardian in 1998 (which had entered the market in 1994 by acquiring Orion Healthcare). The merged group was subsequently acquired by AXA (a French commercial insurer, which has also recently acquired UAP Provincial), though it continues to trade under the well-established PPP brand name in the PMI market. PPP's market share declined slightly during the early 1990s (see Table 4.1), but has recovered over the past three years and is now at 29 per cent.

4.98. As shown in Table 4.2, the next largest supplier is Norwich Union, with a market share of 7.6 per cent in 1999, followed by Standard Life (which traded as Prime Health until recently) with 6 per cent. Both WPA—now the second largest provident-type organization in PMI—and RSA (another general commercial insurer) currently have market shares of about 4.5 per cent, though RSA's share rose during the 1990s, whilst that of WPA declined somewhat. The only other PMI provider with a market share of more than 1 per cent is BCWA (another provident-type organization) which has a 2 per cent share. Other provident-type organizations taken together account for 2.4 per cent; and other commercial insurers taken together account for 3.8 per cent of the market.

4.99. On measures of concentration in the PMI market: the HHI indicates a fall in concentration during the 1990s, mainly reflecting the entry of and expansion by the commercial insurers (Norwich Union, Standard Life and RSA in particular), though the 1999 level of 2,765 continues to indicate a high level of concentration. With the four-firm concentration ratio (CR4), the decline in concentration is less marked. In 1999, the four largest PMI providers accounted for 83 per cent of the market by value.

### ***Entry conditions***

4.100. As shown earlier (see paragraphs 4.93 and 4.94), there have been a dozen or so new entrants to the PMI market during the past decade, most particularly in the early 1990s, when the prospects for growth and profitability appeared encouraging. All the new entrants save Abbey National were well-established general insurance companies enjoying substantial financial resources and well-known brand names (Norwich Union, Guardian, Standard Life, RSA, Allied Dunbar, Cornhill Insurance etc).

4.101. These companies were well placed to overcome some of the main barriers and costs of entry to the PMI market, in particular the need for insurance expertise (including a selling and claims assessment infrastructure), an established and respected brand name, and the resources to cover potentially

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<sup>1</sup>Based largely on data from Laing & Buisson (Appendix 4.1, item 7). BUPA estimated its own share at 38 per cent, using revised revenue data for BUPA PMI.

<sup>2</sup>As explained in paragraph 4.127, PPP used to have equity interests in four hospitals in central London but they were sold to HCA(London) in 2000.

heavy start-up and initial investment costs. Norwich Union told us that its entry had cost around £[ 20 ] million, and that it had operated at a loss for some years (even with a market share of at least 5 per cent), though it had, it told us, achieved a position of modest profitability in recent years. It added that a new entrant would need annual subscription revenues of at least £[ 20 ] million to earn an economic level of profit on the necessary investment in marketing systems and costs. [ 20 ], Standard Life, with a comparable market share to that of Norwich Union, has made underwriting losses in most years since its entry, its accumulated losses being £40 to £50 million.

4.102. Whilst there do not seem to be any significant regulatory barriers,<sup>1</sup> insurance expertise and brand names appear important. It is noticeable, for example, that some of the large general insurers that have entered and continue to trade in this market have chosen to do so by acquiring established PMI providers, for example RSA/Mutual of Omaha and First Choice Health, Orion/Guardian, AXA/Guardian/PPP/UAP Provincial, Standard Life/Prime Health, and QBE International/Iron Trades. Similarly, Abbey National entered by setting up a joint venture with a by then established PMI provider (Norwich Union). Moreover, the BUPA brand name is widely known (and advertised) and is generally considered to be almost synonymous with PMI (ie it is a generic brand). PPP is also an extremely well-established (and well-advertised) brand, and we note that AXA has chosen to continue trading under this brand name in the PMI market. That said, other insurer entrants have come into the market without acquisition and relied on brand names established in related fields and insurance expertise, the most notable and effective being Norwich Union.

4.103. Commercially viable entry has to be on a national scale, with a nationwide distribution system (though use of Internet selling may reduce the significance of this in the future). Such entry also necessitates dealing with hospitals throughout the country on such matters as charges, whether or not a formal network is established. The size of PMI provider is an important determinant of the scale of discounts off standard tariffs or rack rates (see paragraph 4.138) that can be secured from private hospitals. To put it another way, larger PMI providers are able to operate at a lower cost base than the smaller, with regard to the largest area of claims costs. BUPA pointed out to us, however, that many small PMI providers are part of much larger insurance companies with considerable resources and experience.

4.104. A further possible difficulty for new entrants, and for the expansion of the smaller existing PMI providers, is the lock-in effect evident in the personal sector, which arises from PMI subscribers' pre-existing conditions (see paragraph 4.84). This limits the ability and willingness of personal subscribers (but not the corporate sector) to switch between PMI providers in response to price signals.

4.105. Also of possible importance in the context of entry barriers are the high market shares in PMI of both BUPA and PPP, their long-established market leadership, and BUPA's presence in both the PMI and PMS markets. But BUPA told us that entry barriers in the PMI market were low, as was shown by the rate of new entry during the 1990s.

4.106. Notwithstanding the uncertain prospects, some general insurers seem to see commercial benefit in entering the PMI market, at least on a small scale, in order to be able to offer a wider range of services to their customers: Standard Life and RSA told us that this gave rise to increased opportunities for the cross-selling of policy products to existing customers. BUPA told us that, as a specialist health insurer, BUPA PMI would be unable to compete with this advantage.

4.107. But entry (and expansion) on a larger basis, as Laing & Buisson concluded (see Appendix 4.1, item 8), involves higher barriers and greater costs. Greater scale of operation necessitates, among other things, more sophisticated and higher-cost marketing and administration systems. Although there are cost advantages from greater scale, the minimum efficient size of a large PMI provider may involve developing a revenue base of £100 million or more.

## **Networks and preferred provider arrangements**

4.108. As previously mentioned, one of the most significant developments in PMI and PMS markets during the 1990s was the introduction of network-type PMI policies by BUPA, PPP, and also, though to

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<sup>1</sup>Selling of PMI is not supervised by an industry regulator and is not for the most part within the ambit of the FSA; see also Chapter 3 and Appendix 3.7. Indeed, the PMI market is essentially self-regulated, with many PMI providers subscribing to the Insurance Ombudsman Bureau or the Personal Insurance Arbitration Service, and the ABI also provides codes of behaviour and advice to its PMI provider members (see Laing & Buisson, Appendix 4.1, item 7).

a lesser extent, Norwich Union, Standard Life and RSA. Under the terms of these policies, which offer cheaper rates than otherwise equivalent non-network policies (6 to 8 per cent cheaper in the case of BUPA, we were told), policy-holders are restricted—for inpatient treatment—to using hospitals within the relevant PMI provider’s network of approved hospitals. As explained in paragraphs 4.150 and 4.151, BUPA and PPP have negotiated markedly lower PMS charges (higher discounts) for their network business with the PMS providers. BUPA’s network arrangements and terms are not volume-related and do not include any guarantee of an increase in business for network hospitals. PPP’s network agreements, on the other hand, include discounts which are volume-related, in that PPP undertakes to make rebates to the hospitals concerned if volumes fail to reach specified levels.

4.109. From the evidence available to us, it is clear that networks have become a central feature of the linked PMI and PMS markets. The OFT noted in its 1999 review (see Appendix 4.2) that the development of networks had been a reasonable response to relatively static demand for PMI coupled with rising costs and possible excess capacity in the PMS market. Differing views have been put to us on the extent of current capacity and usage, but there is no doubt that network products offered by PMI providers have widened the choice of lower-cost PMI available; and that their introduction may have enabled some personal subscribers to remain in the PMI market at a time of steeply rising premiums for non-network products.

4.110. Nevertheless, the creation of networks has introduced an important additional element to the competitive dynamics of the relationship between PMI and PMS providers. Our analysis of the discount structure associated with network products is presented in paragraphs 4.150 to 4.154. The extent of penetration of network products is also notable: around 40 per cent of BUPA’s policy-holders are on network products and over 90 per cent in the case of PPP; other PMI providers (Norwich Union, Standard Life and RSA) also have partial networks at present and seem likely to develop fully national networks in the coming years.

4.111. It was put to us by small PMS providers that all hospitals outside BUPA’s network were likely to suffer reduced patient volumes for inpatient business<sup>1</sup> as a consequence of their exclusion, both directly and also as a result of consultant drag (the tendency for consultants increasingly to use network hospitals for the treatment of non-network patients).

4.112. The two main networks, as shown in Table 4.3, are those which have been developed by BUPA (165 private acute hospitals out of a total of 216) and PPP (158 hospitals, plus 45 PPU), both of which, we were told, offer comprehensive national coverage, but which limit the choice of subscribers in at least some local areas. BUPA told us that it had always offered its network products alongside its traditional non-network products, and would continue to do this as long as it was economic to do so; it added that over 1 million customers had now chosen to buy the BUPA network product. Similarly, PPP told us that the real choice for customers was between network and non-network products, and that subscribers could readily switch between the two.

TABLE 4.3 Private acute hospitals included in PMI provider networks

	<i>Total number of hospitals</i>	<i>Hospitals in network, by PMI provider:</i>		
		<i>BUPA*</i>	<i>PPP†</i>	<i>Norwich Union</i>
GHG	42	42	41	40
Nuffield	40	39	26	40
<b>BUPA</b>	<b>36</b>	<b>36</b>	<b>34</b>	<b>13</b>
<b>CHG</b>	<b>21</b>	<b>18</b>	<b>20</b>	<b>22‡</b>
HCA(London)	7	6	6	2
Others	<u>70</u>	<u>22</u>	<u>31</u>	<u>2</u>
Total	216	165	158	119

Source: CC, based on information from PMI providers.

\*Excludes psychiatric and other specialist types of hospitals and clinics. The ‘others’ category includes two hospitals in Northern Ireland.

†Excludes psychiatric and other specialist types of hospitals and clinics hospitals. In addition, PPP also includes 45 selected PPUs in its network and a further 19 NHS hospitals without PPUs.

‡Includes a PPU managed by CHG.

<sup>1</sup>Network policies do not usually limit the choice of hospitals where outpatient treatment may take place.

4.113. PPP's network was developed, it told us, mainly on the basis of open competitive tendering, and to that extent represented an outcome of a competitive process, although the hospital selection necessarily involved elements of medical and business judgement by PPP. PPP told us, however, that it had taken great care to collect objective data on the hospitals concerned, and to apply selection criteria in as fair and transparent a manner as possible. Norwich Union has two networks, though neither offers full national coverage. One includes all PPU's and other NHS pay-beds, but not private hospitals (and is linked with Norwich Union's 'Trust Care' product). The other, as shown in Table 4.3, includes 119 private hospitals, but no PPU's: Norwich Union told us that it intended to add hospitals to its network to widen its geographic coverage. This latter network is linked with Norwich Union's 'Fair + Square' product, which was launched in mid-1999, and which at present accounts for less than 5 per cent of Norwich Union's PMI business. Standard Life has also developed a network, but it excludes all GHG hospitals and so does not offer full national coverage.

4.114. In the case of BUPA PMI's network, BUPA told us that it was set up by initially including all GHG, BUPA and Nuffield hospitals, and most of those of CHG, and then adding others to give full national coverage, including small independent hospitals (in areas not covered by the major groups), which BUPA PMI considered to offer adequate quality healthcare and with which it was able to negotiate acceptable price terms. BUPA-owned hospitals currently account for 22 per cent of the total. BUPA told us that it accepted the need for greater transparency in communicating its network eligibility criteria.

4.115. Because BUPA, PPP and Norwich Union seek to achieve national coverage with their network products, each necessarily includes the majority—three-quarters or more—of all private acute hospitals in the UK, so most hospitals owned by GHG, BUPA, Nuffield, CHG and HCA(London) are included. As a result, there is a high degree of overlap between the networks of these groups. PPP told us that this was largely because these hospitals were on the whole better funded and managed than others and therefore provided a higher quality of healthcare. It added that some PPU's had nonetheless been included in PPP's network in preference to larger groups' hospitals because they offered the best combination of care quality and value for money (for example, the selection of Frimley Park had been in preference to a BUPA hospital, and the Stafford Clinic in preference to a CHG hospital).

4.116. All BUPA's hospitals are in its network as are most of those of the other large hospital groups. The three Goldsborough hospitals that were not in BUPA's network at the time BUPA acquired them in January 1998 were brought into the network in 2000 following extensive refurbishment. Three CHG hospitals—Berkshire Independent, North Downs and Oaklands—are excluded from BUPA PMI's network. BUPA told us that IBH, the previous owner of these three hospitals, had not been interested in joining the network and that, since CHG acquired them, BUPA had had no need of additional network facilities in the areas concerned. It added that these three hospitals had not been excluded because of their proximity to BUPA-owned hospitals. CHG, on the other hand, told us that the three hospitals were in local catchment areas in direct competition with those of BUPA.

4.117. Norwich Union includes all the PPU's in its network and PPP includes 45, but BUPA does not include any. As for the 70 independent hospitals (including the smaller groups, each consisting of two or three hospitals—see Table 4.4), about one-half do not appear to be in either the BUPA or PPP networks. Of those that are, about two-thirds are in both, and the remaining one-third are in one or the other.

4.118. BUPA told us that its network had not changed materially since it was established, and it had not delisted any hospitals. It added that the only voluntary exit from its network had been St Anthony's Hospital, and this had reflected a series of commercial disputes which had arisen between them (see Chapter 6).

4.119. Networks have been at the centre of many of the competition concerns raised by third parties to this inquiry. It has been put to us that BUPA's selection process is inherently anti-competitive, in that it is subjective and non-transparent (see paragraph 4.117); it creates added uncertainty (inclusion in the network is typically for three years, and subject to renewal); and as a result, it was claimed, it is discriminatory, and unfairly disadvantages the smaller independent hospitals (see paragraph 4.114 and Chapter 6). GHG told us that, in an area with BUPA and non-BUPA hospitals, BUPA could rotate the non-BUPA hospitals on successive three-year contracts, reducing the incentive of each to invest in technology, thus further reducing the number of patients and funds available for investment.

4.120. The four national PMS providers told us that patient volumes had not grown markedly, or as much as had been expected, since their inclusion in the PMI providers' networks. But Laing & Buisson estimated that the potential loss for small independent hospitals that were excluded from the larger networks could be up to 30 per cent of revenue.

4.121. Preferred provider arrangements are essentially networks of a sort but they are not on a fully national scale and may take various forms. In some cases, they relate to agreements (including preferential terms) between a PMI provider and a particular hospital group (for example, Norwich Union has such an agreement with Nuffield; and Standard Life has one with BUPA PMS). More commonly, preferred provider arrangements relate to large company PMI schemes, where the insurance cover may often be regionally or locally based. Under such arrangements, insurer-paid medical treatment may be limited to named hospitals within a given locality, as agreed between the PMI provider and the company concerned<sup>1</sup> under the negotiated terms of the policy.

## **PMS national market analysis**

4.122. In this section we consider the PMS market at the national level, dealing with aggregate demand and the value of services (sales revenues) provided by private acute hospitals; mergers and acquisitions during the 1990s; the current market shares of PMS providers; measures of capacity usage; hospital charges; and entry conditions. Our evaluation has particular regard to the changes in and evolution of the market during the 1990s, and the expected effects of the proposed merger between BUPA and CHG.

### ***Sales revenues, market shares and capacity***

4.123. As explained earlier, the PMS market is served primarily by privately-owned acute hospitals and, to a lesser extent, by PPUs in NHS hospitals. Private acute hospitals typically have the necessary medical facilities for, and carry out on a regular basis, a wide range of elective surgery and other medical treatments, including inpatient, day-case and outpatient work. At present, the largest private acute hospital in the UK, measured by numbers of beds, is the Wellington in London, which has 250. As in the PMI market, PMS providers include both not-for-profit, charity-based organizations (for example, Nuffield), provident-type organizations (for example, BUPA) and fully commercial companies (for example, GHG and CHG).

4.124. At present, there are 97 NHS PPUs in the UK, the largest being those within the London area. PPUs are separate from the public wards of NHS hospitals, but they generally do not have dedicated staff or operating facilities, and they are mostly smaller than private hospitals: just over one-half of PPUs offer 12 beds or fewer. The largest is the Royal Free in Hampstead, which has 57 dedicated beds, while the smallest (the Ayr in Kilmarnock), has only four. The NHS also permits around 1,500 of its beds in wards to be used for private patients, subject to availability. As explained earlier (paragraph 4.65), we have excluded these types of beds from our market analysis.

4.125. Expenditure on PMS grew rapidly during the 1980s (at more than 10 per cent a year in real terms). The rate of growth slowed somewhat during the 1990s, but expenditure and revenues nevertheless doubled in nominal terms and grew on average by nearly 5 per cent a year. These revenue trends were matched by a rapid and large expansion in PMS capacity. In the period 1980 to 1985, nearly 50 new private acute hospitals were built, and the number of beds increased by around 3,000. Over the next decade growth slowed, but a further 27 hospitals and 1,600 beds were added.

4.126. Although there has been a modest rise in the number of private hospitals since 1996, the number of available beds has fallen. This appears to reflect saturation of demand and also the effects of

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<sup>1</sup>[

*Details omitted. See note on page iv.*

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developments in medical technology, which have led to a shift in the balance of treatments from inpatient to day-case and outpatient treatment. As shown in Table 4.4, by mid-1999 there were 11,800 dedicated private acute care beds at 313 separate private and NHS hospitals. Of these beds, 87 per cent or 10,300 were in 216 private acute hospitals (an average of 48 beds per hospital); and the remaining 1,500 or so were in 97 NHS PPUs (an average of 16 beds per PPU). In 1998, PMS revenues amounted to about £1.7 billion, of which private acute hospitals accounted for £1.4 billion (82 per cent) and NHS/PPUs for £0.3 billion (18 per cent).

4.127. There have been many mergers and changes of PMS ownership since the 1990 report (see Appendix 4.1, items 1 and 9), and an increase in concentration, reflecting the emergence and expansion of the four national PMS providers and the exit from the market of smaller, independent hospitals. Having acquired HCA in the early 1990s, BUPA subsequently bought Goldsborough in 1997. GHG and Amicus merged in 1998 and bought the Victoria Park hospital from CHG in the same year: the merged GHG was owned by funds controlled by Cinven Ltd, but has recently been sold to funds controlled by B C Partners, a venture capital group which has no other PMS interests. CHG bought the IBH group in 1998. Nuffield acquired two independent hospitals in 1998 and another in 2000. PPP acquired an equity stake in PPP/Columbia Healthcare in 1996, but has recently exited the market, with its hospitals now forming part of the HCA(London) group. Abbey Hospitals entered the market in 1997 by acquiring four hospitals from IBH, subsequently acquired a further four, but closed one and merged another two, leaving it with six.

4.128. As a result of these mergers among the larger groups, Goldsborough and IBH have left the PMS market, albeit that the hospitals involved continue to operate. Similarly, Aspen, Compass and St Martin's Hospitals have each been taken over or merged with other groups since 1990. There have also been several recent hospital closures, particularly among the smaller independent hospitals. Beaconsfield Hospital (owned by Bon Secour) closed in 1999, as did the Churchill Clinic and Manor House Hospital in London, the Stamford Hospital, the Daresbury Wing (Warrington), and St Vincent's Hospital.

4.129. As explained by Laing & Buisson (Appendix 4.1, item 9), the merger activity and market exits during the 1990s have led to increases in concentration. In their view, these changes have been caused by economies of scale at the hospital group level, particularly in purchasing; the high capital requirements for new medical equipment or upgrading facilities; elements of excess capacity; and the effects of PMI providers' network policies. BUPA said that these factors had put pressure on hospital costs and required them to improve their efficiency.

4.130. Table 4.4 gives details of the current structure of the PMS market at the national level in terms of market shares of PMS providers, numbers of hospitals, bed capacity and revenues.<sup>1</sup> (In our view revenue is to be preferred as the basis for measuring market shares, because it reflects physical capacity, its utilization, and variations in the mix of procedures and services.) There are currently four national PMS providers. GHG is the largest in terms of numbers of hospitals (40, of which three are in London), beds (2,100) and revenue share (20 per cent). Nuffield also has 40 hospitals, but considerably fewer beds (1,600) and accounts for only 12 per cent of the market by value. BUPA currently has 36 hospitals and CHG 22 (of which one is a PPU, which CHG manages). Together, BUPA and CHG have 2,600 beds (1,800 and 800 respectively), and a market share of 22.5 per cent by value: as a result, a merged BUPA/CHG would be the largest hospital group. HCA(London) ranks above Nuffield by revenue but has no national coverage. The 51 hospitals shown in Table 4.4 in the 'others' category mainly comprise independent hospitals, many of which are charity-owned. The 97 NHS PPUs collectively have a PMS market share of 18 per cent, but they are managed as separate units, not as a unified group, and so do not compete as a national PMS body although their aggregate revenue exceeds that of all the PMS providers save GHG.

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<sup>1</sup>We have used 1998 revenues as the basis for calculating market shares because these were readily available. Late in the inquiry, 1999 revenue data became available. These data indicate that PMS revenues in 1999 were 10 per cent or so greater than in 1998, but that market shares were not markedly different.

TABLE 4.4 Number of private acute hospitals, number of beds (1999), revenue (1998) and market shares

Operator	Number of hospitals*	% share of private acute hospitals†	Number of beds	% share of private acute beds‡	1998 revenue £m	% share of 1998 revenue‡
<b>BUPA</b>	<b>36</b>	<b>16.7</b>	<b>1,808</b>	<b>15.3</b>	<b>292.4</b>	<b>17.4</b>
<b>CHG§</b>	<b>22</b>	<b>10.2</b>	<b>843</b>	<b>7.1</b>	<b>85.6</b>	<b>5.1</b>
<b>BUPA/CHG combined</b>	<b>58</b>	<b>26.9</b>	<b>2,651</b>	<b>22.4</b>	<b>378.0</b>	<b>22.5</b>
GHG	40	18.5	2,146	18.1	338.0	20.1
Nuffield	40	18.5	1,617	13.7	195.9	11.7
HCA(London)	6	2.8	748	6.3	135.8	8.1
King Edward VII	2	0.9	191	1.6	19.5	1.2
Abbey Hospitals	8	3.7	190	1.6	4.5¶	0.3
Aspen Healthcare	2	0.9	127	1.1	22.5	1.3
Bon Secour‡	2	0.9	108	0.9	6.0	0.4
Healthcare	2	0.9	70	0.6	12.9	0.8
Scotland						
HMT	2	0.9	63	0.5	8.0	0.5
Surgicare#	3	1.4	24	0.2	N/A	N/A
Others	51	23.6	2,365	20.0	256.9	15.3
NHS PPU <sub>s</sub>	97	-	1,534	13.0	303	18.0
Total	313	100.0	11,834	100.0	1,681	100.0

Source: CC, based on information from Laing & Buisson, The Fitzhugh Directory, and PMS providers.

\*Excludes British Pregnancy Advisory Service and Marie Stopes International (fertility treatment and pregnancy termination).

†Excludes NHS PPU<sub>s</sub>.

‡Includes NHS PPU<sub>s</sub>.

§Includes one NHS PPU managed by CHG (Fotheringay Suite).

¶1997 (1998 figures not available).

‡Bon Secour exited the market during 1999.

#Late in the inquiry Surgicare told us that it owned only one of the three main hospitals it worked from.

4.131. As regards measures of concentration, the HHI for the PMS market in 1999 is estimated at 950 on a revenue basis (and treating each NHS PPU as a separate supplier: if PPU<sub>s</sub> were treated as a single group, the HHI would be 1,267). This compares with an HHI of about 650 in 1988/99, which indicates that there was a marked increase in concentration in the PMS market during the 1990s. An HHI of 950 nevertheless indicates a modest level of concentration. Were BUPA and CHG to merge, the index would increase by a further 180 points to 1,130—still a modest level of concentration.

4.132. BUPA suggested that the HHI measure in this instance may not be an appropriate measure because of the local and regional competition aspects of the PMS market. Moreover, the HHI tends to understate the real level of concentration because (a) the smaller independents and individual PPU<sub>s</sub> operating independently do not present an effective competitive challenge to the four national PMS providers which have emerged during the 1990s; (b) the London area is a distinct market segment (see paragraph 4.68); and (c) the HHI fails to take account of the increasing importance of the hospital networks developed by PMI providers. As regards the four national PMS providers, the four-firm concentration ratio (CR4) measured by shares of revenue has risen from 44.5 per cent in 1988/99 to 57.3 per cent in 1999: the proposed BUPA/CHG merger would increase that to 62.4 per cent. On this basis, the merged BUPA/CHG would account for about 36.1 per cent of the PMS revenues of the then four largest PMS providers, ie BUPA/CHG, GHG, Nuffield and HCA(London).

4.133. If HCA(London) were excluded from these figures (on the grounds of London being a distinct market segment—see paragraph 4.68), the merged BUPA/CHG would account for about 41.5 per cent by value of sales of the large PMS provider groups operating outside London. Moreover, in relation to the two main hospital networks (see paragraph 4.112), the merged BUPA/CHG would account for 33 per cent of the BUPA network hospitals and 35 per cent of the PPP network. To the extent that BUPA/CHG hospitals are both larger than the independent hospitals in these two networks, and their PMS charges also tend to be higher, the merged BUPA/CHG would account for a somewhat higher proportion of both PMS capacity and revenues within the two networks.

4.134. It was put to us that there was excess capacity in the PMS market. Medisure and others told us, for example, that private acute hospitals were much underused, especially in the evenings, weekends

and holiday periods, and that there was a clear potential for achieving far higher levels of activity. The traditional measure of PMS capacity usage has been overnight accommodation occupancy levels, expressed as a percentage of available beds across a seven-day week. On this basis, the average occupancy level is currently just under 50 per cent.

4.135. Others (including BUPA) told us, on the other hand, that there was not much excess capacity in the PMS market and that occupancy level was not of itself a useful or meaningful indicator of capacity utilization. In large part, they said, this was because occupancy level failed to take account of the limited surgical theatre capacity available; the inevitable restrictions on evening, weekend and holiday work (arising primarily from consultants being unwilling to work at these times); the need for private hospitals to be able to offer treatment without delay; and the dramatic shift from inpatient to day-case work. BUPA estimated that private hospital occupancy was as high as 75 per cent when measured using effective patient days, which took into account day-case patients. This degree of utilization was much closer to the maximum levels of occupancy a hospital could sustain. BUPA added that, even using the traditional occupancy level measure, the breakeven level was about 40 per cent or so, suggesting that, on average, private hospitals were performing reasonably efficiently.

4.136. For the purposes of this inquiry, we do not consider it necessary to take a view on whether or not there is significant excess capacity in the PMS market overall, albeit that competition effects arising from the merger might be exacerbated in conditions of full capacity. We note, however, that there has been a net reduction in capacity in recent years, in part reflecting hospital closures (see paragraph 4.127); and that part of the rationale for the introduction of hospital networks was to improve the capacity utilization of the hospitals included within them and thereby reduce average fixed costs.

### ***Hospital charges***

4.137. PMS charges account for 80 per cent of the total revenues of PMS providers (about £1.7 billion in 1998; see Table 4.4), and they are also the largest individual element of PMI providers' costs: indeed, they account for more than one-half of the total (with consultants' fees accounting for a further quarter). As such, they are of central importance to the competitiveness and profitability of both PMS and PMI providers.

4.138. In broad terms, most hospital charges are negotiated between PMI and PMS providers within a typically three-year agreement, reviewed on an annual basis, mainly in relation to the level of discounts<sup>1</sup> off PMS providers' rack rates (standard single treatment episode tariffs) and percentage annual increases reflecting inflation in medical costs. Terms are negotiated separately for standard (non-network) business, for the treatment of network patients and for preferred provider arrangements. The main PMI providers and the four national PMS providers negotiate on the basis of average charges for all hospitals within a given group—effectively a national average price—a practice which has developed and become of greater importance during the 1990s, particularly as concentration in the PMS market increased and also with the advent of network policies.

4.139. These negotiated charges relate primarily to the main elements of hospital services, including overnight and day-case accommodation rates, charges for surgical theatre use, and the use of diagnostic equipment (for example, MRI and CT) etc. In addition, package prices for some common procedures (for example, cataracts, hernias and hip replacements) may also be negotiated as part of this process. BUPA told us, for example, that BUPA PMS has negotiated such common procedure prices with BUPA PMI and PPP (in both cases, such business accounts for about one-half of the total by value), but not with other PMI providers. Self-pay prices, ie charges to non-insured patients, tend to be determined more on a case-by-case basis, largely as a matter between the individual patient and the hospital, though the patient's consultant may also be involved in the negotiations. The larger PMS providers, however, usually establish self-pay prices centrally, and guide prices, or price ranges, may also be set, and in some cases advertised, on a national basis.

4.140. Because hospital charges to PMI providers are largely an outcome of a bargaining process with PMS providers they (a) reflect the bargaining strength and abilities of the two sides (rather than necessarily the underlying structure of supply costs); and (b) are known only to the parties concerned (indeed, they are regarded as highly confidential), and are therefore not transparent to the market as a

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<sup>1</sup>BUPA told us that it negotiated hospital charges predominantly on an annual basis, and in relation to the level of such charges rather than as discounts from 'rack-rates'.

whole. We were told that the four national PMS providers enjoy substantial advantages relative to the smaller groups (for example, HMT) and stand-alone independent hospitals, by virtue of their greater scale of operation, their wider geographical coverage and the solus and flagship hospitals which they own. These features are of particular value in price negotiations with the major PMI providers concerning network arrangements and associated charges. HCA(London) (the fifth largest group in capacity terms, but the fourth largest measured by value of turnover) and some of the large independent London hospitals are in a special position, by virtue of their market strength in the London market segment; see paragraph 4.68.

4.141. The two largest PMI providers (BUPA PMI and PPP) enjoy substantial bargaining advantages over smaller providers, primarily because of their greater scale of operation: taken together, they account for about 70 per cent of PMI business with PMS providers (see Table 4.2). They also gain advantage from their considerable knowledge of (and information databases on) treatments and hospital costs. As a result, and as further explained below, both BUPA and PPP generally obtain better terms from PMS providers than do smaller PMI providers,

4.142. Meaningful comparisons of PMS charges to PMI providers and self-payers are inherently difficult because of the complexities involved. Some charges are on the basis of hospital service elements (which cover a wide range of individual services), whilst other charges relate to package prices for common procedures, some of which are either fixed prices or are agreed within a specified range. Within that dual price structure, PMS charges typically change annually, sometimes on different dates; different PMI providers may have different requirements; and there are also likely to be qualitative differences between PMS providers in respect of accommodation standards, special treatment facilities and location advantages. Moreover, in addition to the charges agreed for standard business, there are also extra discounts relating to network arrangements, and in some cases discounts are related to the volume of business.

4.143. Notwithstanding this inherent complexity, we sought for the purposes of this inquiry to explore where possible: (a) the relative level of charges by different PMS providers (particularly BUPA and CHG); (b) the scale of standard and network discounts obtained by different PMI providers; (c) whether BUPA PMI obtains preferential terms from BUPA PMS; and (d) the relationship between charges to insured and self-pay patients.

4.144. As regards comparisons across the four national PMS providers, BUPA provided data to us based on its ECI. As mentioned earlier (paragraph 4.47), this is a BUPA-calculated weighted average of PMS treatment episode charges to BUPA PMI, where the weights used include measures of clinical practice (including length of stay, case-mix and the day-case proportion). BUPA uses this index to compare the weighted average prices of different hospital groups one with another and in relation to the national average, this being taken as the base of 100 (based on 1996 data). For 1999, the index for inpatient charges (C-band standard of accommodation) shows that both BUPA PMS and CHG charges were at the average level of 100, GHG prices were 2.5 per cent higher (ie GHG had an index value of 102.5), and Nuffield's prices were 3.1 per cent lower. The ECI data for day-case business showed that BUPA PMS charges were nearly 20 per cent above the average (with an index value of 119.7), about 3.5 per cent higher than those of CHG, about 14 per cent greater than GHG day-case charges, and 30 per cent or so above those of Nuffield.

4.145. To evaluate hospital charges more generally, we obtained data on current charges directly from both PMI and PMS providers, and carried out our own analysis. These pricing data are summarized in Tables 4.5 to Table 4.8. Table 4.5 gives details of the current, standard business tariff charges (ie for non-network business only) by the four national PMS providers to the five largest PMI providers (see Table 4.20), for some of the main hospital services provided. The data in Table 4.5 are based largely on information given to us (on a confidential basis) by PMI providers. As a result, for any given PMI provider, the charges of different PMS providers are on a common basis, though there may be differences between PMI providers in their basis of calculation.

4.146. GHG and others told us that the overnight accommodation rates (an inpatient stay is typically for three to four nights) and day-case accommodation rates (an expanding area of business) were regarded as especially important by both PMI and PMS providers. As shown in Table 4.5 (and putting aside for the moment BUPA PMS's charges to BUPA PMI), the charges by BUPA PMS for overnight accommodation are in almost all instances higher than those for the other PMS providers. BUPA PMS's charges to PPP, Standard Life and Norwich Union are about [ 20 ] per cent higher than those of CHG.

For the other charges listed, the position is less clear-cut, in part reflecting the complexities of the pricing arrangements. BUPA PMS's charges to Norwich Union for both day-case accommodation and MRI, for example, are higher than those of other PMS providers; but its charges to Standard Life and RSA for these same services are among the lowest.

4.147. Overall, the data in Table 4.5 indicate that CHG's charges for hospital services are generally less than those of BUPA PMS. Whilst this is only partially confirmed by BUPA's ECI calculations (see paragraph 4.47), BUPA told us it accepted that CHG's charges were somewhat below those of BUPA PMS; and that if the merger went ahead, BUPA expected to bring CHG prices into line with those of BUPA PMS, following and reflecting the additional investment that BUPA would expect to undertake in CHG's hospitals (see also paragraph 3.154).

TABLE 4.5 **Hospital service charges (standard business tariffs) by the four national PMS providers to the five largest PMI providers, 2000**

Service*	PMI provider					£
	BUPA PMI	PPP†	Norwich Union	Standard Life	RSA	
<i>Overnight accommodation rate (C scale)</i>	<div style="font-size: 4em; font-weight: bold;">(</div> <p style="text-align: center;">Figures omitted. See note on page iv.</p> <div style="font-size: 4em; font-weight: bold;">)</div>					
BUPA PMS						
GHG						
Nuffield						
CHG						
<i>Day-case accommodation rate (maximum charge)</i>						
BUPA PMS						
GHG						
Nuffield						
CHG						
<i>Theatre charges + consumables (intermediate surgery)</i>						
BUPA PMS						
GHG						
Nuffield						
CHG						
<i>MRI charge (one site)</i>						
BUPA PMS						
GHG						
Nuffield						
CHG						
	% discount from rack rate					
<i>Weighted average of all services</i>	[ Figures omitted. See note on page iv. ]					
BUPA PMS§¶						

Source: CC, based on figures from PMI and PMS providers.

\*Inpatient accommodation (all scales) accounts for an average [ 30 ] per cent of BUPA PMS's revenues from the top five insurers, day-case accommodation for [ 30 ] per cent, theatre costs (intermediate surgery) for [ 30 ] per cent and MRI for [ 30 ] per cent.

†PPP's overnight accommodation rates are not banded.

‡Medical packages only: separate prices for surgical day-cases.

§Percentage discount from standard tariff of each service item (including those listed above, but excluding CT and perfusion, for which data were not available) weighted by share of total revenue from each insurer. Around one-half of BUPA PMS's revenues from BUPA PMI, and from PPP, are from packaged services. For ease of comparison, these were excluded and other items were upweighted accordingly. Basic discounts achieved by BUPA PMI and PPP for packaged services are broadly similar, but additional discounts (see below) of [ 30 ] to [ 30 ] per cent to BUPA and [ 30 ] per cent to PPP also apply. Other PMI providers also achieve discounts from their standard business tariffs from PMS providers.

¶BUPA PMI achieves a further [ 30 ] per cent network discount from BUPA PMS for its LocalCare network product, and [ 30 ] per cent for its Health Fund network. PPP achieves an additional discount from [ 30 ] BUPA hospitals, ranging from [ 30 ] to [ 30 ] per cent. The average value, to PPP, of this discount across all BUPA hospitals (weighted by hospital share of BUPA PMS insurers revenue in 1999) was around [ 30 ] per cent.

4.148. As mentioned above, a substantial proportion of PMS business is charged for on the basis of a package price for certain common procedures. Table 4.6 gives details of the current charges by BUPA PMS and CHG to five of the main PMI providers for six common procedures. These six taken

together account for nearly [ 30 ] per cent of BUPA PMS's common procedure charges to BUPA PMI. As far as possible, the charges shown are on a broadly common basis, in so far as they are all average realized charges covering both network and standard business, and they all include the cost of all consumable items (drugs, dressings, prosthesis etc) but not consultants' fees. For each individual PMI provider the charges by BUPA PMS and CHG are on a comparable basis, though there may be some differences in the make-up of charges and also the basis of calculation as between different PMI providers.

TABLE 4.6 Current average charges by BUPA PMS\* and CHG† to PMI providers for six common procedures

£ (CHG's % discount/premium against BUPA PMS shown in parentheses)

Procedure	PMI provider									
	BUPA PMI		PPP		Norwich Union		Standard Life		RSA	
	BUPA PMS*	CHG	BUPA PMS	CHG	BUPA PMS	CHG	BUPA PMS	CHG	BUPA PMS	CHG
Total prosthetic replacement of hip										
Phakoemulsification of lens (cataracts)										
Therapeutic endoscopic operation of knee										
Endoscopic resection of prostate										
Primary repair of inguinal hernia										
Tonsillectomy—adult (including bilateral)										

*Figures omitted. See note on page iv.*

Source: CC, based on figures from PMI providers (including BUPA).

\*Fixed charges. PPP also agrees fixed charges with BUPA PMS but these vary by hospital. PPP figures shown are averages.

Note: N/A = not applicable.

4.149. More importantly, however, comparisons between PMI providers are affected by differences in the proportion of the average charge accounted for by network business, where discounts are higher (over 90 per cent of the average charges to PPP relate to network business, for example, compared with 40 per cent in the case of BUPA). Nonetheless, the data do indicate the broad level of charges for different procedures, and meaningful comparisons between BUPA and CHG are also possible. Table 4.6 facilitates such a comparison by showing the percentage discount or premium of CHG's charges relative to those of BUPA PMS. For example, CHG's charge to PPP for a cataract operation is [ 30 ] per cent lower than that of BUPA PMS, and CHG's charge to BUPA PMI for a hip replacement is [ 30 ] per cent higher than that of BUPA PMS. CHG's charges to PMI providers for these procedures are mostly below those of BUPA PMS, and markedly below in some instances, for example CHG's charges to Norwich Union for both cataract and knee operations are about [ 30 ] per cent less than those by BUPA PMS.

4.150. Turning to the discounts obtained by different PMI providers, BUPA and others told us that the larger PMI providers obtain higher discounts from all PMS providers than other PMI providers are able to negotiate, because of the greater volume of business involved. Both the smaller PMI providers and independent hospitals put it to us that these discounts were disproportionately large, and reflected greater bargaining power rather than any genuine cost savings. Nuffield and [ 30 ] told us that BUPA PMI had attempted in the past to ensure that PMS providers would always let it have the lowest price, and that it sought comfort letters to that effect: see Chapter 6.

4.151. The data we collected suggest that BUPA PMI in most instances obtains better terms from all PMS providers than do other PMI providers. BUPA told us it believed that on average it obtained dis-

counts (off PMS providers' rack-rates) of 25 to 35 per cent for non-network business, and a further [ 30 ] per cent for its network business. As the second largest PMI provider, PPP has also been able to negotiate high levels of discount with PMS providers (where these are related to the volume of extra business generated). [

*Details omitted. See note on page iv.*

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TABLE 4.7 [ *Details omitted. See note on page iv.* ]

<p><i>Details omitted. See note on page iv.</i></p>
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4.152. Many PMI providers suggested to us that BUPA PMI obtains preferential terms from BUPA PMS. BUPA, however, told us that its PMI and PMS businesses operated entirely independently, and that hospital charges were negotiated between them on a strictly arm's length basis. It also told us that its ECI calculations (see paragraph 4.47) did not indicate that BUPA PMS charges to BUPA PMI were markedly lower than those by other PMS providers which operated on a national basis.

4.153. Our data, however, are on a more disaggregated basis than BUPA's ECI. As shown in Table 4.5 covering hospital service charges for non-network business, BUPA PMS's charges to BUPA PMI are indeed generally lower than those to other PMI providers. But we note also that BUPA PMI appears to obtain a particularly favourable rate from BUPA PMS for overnight accommodation (£[ 30 ] per night): it is markedly lower than for the other three PMS providers that operate on a national scale, and indeed is some [ 30 ] per cent below the equivalent charge by CHG. Moreover, the equivalent BUPA PMS charge to PPP (£[ 30 ]) is some [ 30 ] per cent greater than that to BUPA PMI, and the equivalent charge to Norwich Union is over [ 30 ] per cent more.

4.154. Also of relevance to this issue are the data given in Table 4.8, which gives details of charges for six common procedures, covering both standard and network business separately, with all the data being presented in index form (using BUPA PMS's non-network charges to BUPA PMI as the base of 100). As shown in the table, the smaller PMI providers in particular are charged markedly more than BUPA PMI: for knee operations, for example, the differential is of the order of 50 per cent. For network business, BUPA PMS charges BUPA PMI up to 20 per cent less than for standard business. By contrast, BUPA PMS's network-based charges to PPP for three of the six cases are around 10 per cent more than the equivalent charge to BUPA PMI for non-network business. We note that although PPP has a smaller overall market share than BUPA PMI, a far higher proportion of its business is on network products (see paragraph 4.82). As a result, the volume of PPP network business with BUPA PMS is likely, other things being equal, to be greater than for BUPA PMI.

4.155. Turning to the relationship between PMS charges to PMI providers and self-paying patients, [

*Details omitted. See note on page iv.*

]. It was put to us, by WPA in particular, that PMS providers were abusing their position by charging PMI providers such as itself more than self-paying patients.

4.156. Table 4.8 provides details of BUPA PMS charges (in index form) for six common procedures to self-paying patients relative to those insurers. These data indicate a more mixed picture. For cataracts, BUPA PMS's self-pay rate is lower than that for the smaller PMI providers and for hip replacement, there are three higher, one lower and one the same. But for the other four procedures, the smaller PMI providers' charges are almost always higher for self-paying patients (ie with respect to knee operations, tonsillectomy, hernias and prostates).

TABLE 4.7 Average hospital charges by BUPA PMS, under both network and non-network arrangements

Index: BUPA non-network = 100

Procedure	Network*		PMI providers Non-network business							
	BUPA	PPP	BUPA	PPP	Norwich Union	SLH	RSA	WPA	BCWA	Self-funding
Phakoemulsification of lens (cataracts)	80	95	100	-	127	128	124	129	129	113
Therapeutic endoscopic operation on knee	82	108	100	114	147	153	146	163	165	188
Tonsillectomy—adult (including bilateral)	84	114	100	127	96	100	92	105	112	147
Primary repair of inguinal hernia	83	96	100	103	96	93	94	92	99	152
Total prosthetic replacement of hip	83	112	100	-	131	126	114	120	135	120
Endoscopic resection of prostate	81	100	100	110	104	109	100	106	128	122

Source: CC, based on figures from BUPA.

\*Package prices are not available to Norwich Union network members for most procedures.

### Entry conditions

4.157. New entry to the PMS market, or expansion by existing PMS providers, may take the form of either building or acquiring hospitals. Both of these possible entry strategies are subject to a range of entry barriers.

4.158. In general terms, the market does not appear attractive for a new entrant: Laing & Buisson reported that the current trend of hospital closures in the private acute hospital market indicates that capital expenditure on new developments is a high-risk investment, and that 'on current trends, it would take many years for market growth to take up existing spare capacity and create sufficient additional demand for a new wave of investment'. Laing & Buisson's approach of measuring capacity utilization on a bed occupancy basis may tend to exaggerate the extent of overcapacity in the market (see paragraph 4.135), but it nevertheless appears that some spare capacity currently exists. Similarly CHG told us that the PMS market was not growing because the PMI market was static, and this lack of growth restricted new entry or expansion in PMS.

4.159. A new entrant or existing hospital group wishing to build a new hospital would have to identify a location where such a development could be justified by the level of demand for medical services in the area. In practice, the existing PMS providers together have a more or less national coverage, particularly in more densely populated areas, so it would be necessary for the new entrant to compete against an established incumbent.

4.160. As mentioned in paragraph 4.24, consultants generally have an established relationship with existing hospitals in their area. The need to secure such relationships could be a serious barrier to a new entrant, who would need to identify consultants prepared to work in new surroundings and gain their confidence and interest. On average, consultants carry out around 70 per cent of their private work in a single hospital, so it would be necessary to persuade a substantial number of consultants to move the majority of their work to the new hospital.

4.161. Apart from staffing problems, which vary with location, there are several other practical barriers to building a new hospital. Under the Registered Homes Act 1984 (see Appendix 3.7), all private hospitals must be registered with the HA in whose area they are located. Before registering the hospital, the HA must be satisfied that the facilities, accommodation and staff of the hospital are suitable for the type and condition of patients for whom care will be provided. The availability of planning permission is uncertain, and it is time-consuming to obtain. BUPA told us that in some cases the most appropriate site for a hospital would be one where planning permission would not be readily available.

4.162. Construction costs can vary widely with hospital size and construction quality. BUPA told us that a typical 52-bed private acute hospital with its own infrastructure (including operating theatres, pathology laboratory, pharmacy and medical stores) would cost around £8 million to build, and that land costs, specialist equipment and other costs would add a further £3 million to £4 million. CHG estimated the cost of building and equipping a 50-bed hospital, with two or three operating theatres, at around £10 million. BUPA said that a typical construction would take 18 to 24 months from start on-site to first patient admission.


4.163. A new hospital would also need to negotiate for recognition by the main PMI providers. BUPA told us that hospitals meeting HA registration standards would generally be recognized by the larger PMI providers. However, a new hospital, particularly one that did not belong to an existing large hospital group, might have considerable difficulty in securing inclusion in the networks of the main PMI providers. Laing and Buisson, for example, said that ‘BUPA and PPP ... are both discouraging new private hospitals, in keeping with their network strategies’. In this light, network membership can be seen as a barrier to entry which reflects the policies of BUPA PMI, PPP, and to a lesser extent Norwich Union and Standard Life.

4.164. Acquisition of existing hospitals is an alternative entry or expansion strategy to investing in new hospitals. The main constraint on acquisition is that not many hospitals are potentially for sale. The smaller groups account for around 25 hospitals, while around 50 more are independents. Many of the latter are charity-based organizations, unlikely to sell to a commercial organization and protected from hostile takeover. CHG told us that there were still a few hospitals that could be acquired from the small groups and independents. However, it said that it had attempted to expand by acquisition in 1998 and 1999, but had not succeeded because it had been outbid by venture capital companies. Recent acquisition activity has largely taken the form of consolidation by the larger groups, rather than by new entry or expansion of smaller groups, with the notable exception of Abbey Hospitals’ entry (see paragraph 4.127).

## **PMS local markets and wider areas**

4.165. This section presents the results of analysis carried out on the local PMS markets affected by the merger. In particular, we focus on the areas in which the individual CHG hospitals operate, and seek to identify: (a) the incidence of solus CHG hospitals or solus situations following the proposed merger (see paragraph 4.178); (b) the areas in which BUPA and CHG compete at present, and hence in which the proposed merger might lead to a reduction in competition; and (c) the relevance of flagship hospitals. We also note the wider areas where there may be concern as to effects on competition.

### ***Local area analysis by BUPA and the OFT***

4.166. First, we review the local area analysis produced by the OFT and BUPA in the context of the proposed merger. In its submission to the OFT BUPA identified [  ] areas of substantial overlap

between BUPA and CHG hospitals. It considered the degree of local competition by reference to catchment areas determined by area-specific evidence, including patient discharges and HA areas. The OFT measured the market share of BUPA and CHG in each of these areas on the basis of the number of inpatient beds in competing hospitals within a 20-mile radius. The OFT also identified a further [ ⌘ ] areas of substantial overlap. Together these [ ⌘ ] areas contained 12 CHG hospitals, as shown in Appendix 4.4. However, the OFT identified two of these, Euxton Hall and Renacres Hall, as not competing with BUPA hospitals. The OFT when assessing the extent of competitive overlap also took into account data on the locations (defined by postcodes) to which patients were discharged from BUPA and CHG hospitals.

4.167. The disadvantages of using a 20-mile radius to identify a catchment area are discussed in paragraph 4.170. We also note here that the measurement of market share based on the number of beds in hospitals in the area has considerable drawbacks. As discussed in paragraphs 4.134 and 4.135, the number of beds in a hospital is not a wholly satisfactory measure of its capacity, and does not account for differences in capacity utilization. In addition, no distinction is made between a hospital in the middle of an HA area and one close to the boundary, while any hospital just outside the boundary is excluded.

4.168. In the course of the present inquiry BUPA provided us with an analysis of overlaps between its hospitals and eight of the CHG hospitals about which the OFT had raised competition concerns. (These were Berkshire, Fulwood Hall, North Downs, Oaklands, Pinehill, Rivers, Springfield and Yorkshire Clinic.) The study focused on the postal sectors of the homes to which patients were discharged by each hospital.<sup>1</sup> The number of sectors for each hospital ranged from 130 to 300. Postal sectors were counted as having a substantial overlap of BUPA and CHG patients where (a) they generated at least 0.5 per cent of the discharges of both hospitals, and (b) both hospitals had more than 20 per cent of the combined patient discharge total in that postal sector. The analysis found that 78 per cent of discharges from Berkshire Independent were to postal sectors where there was substantial overlap with BUPA. The corresponding figures were 45 per cent for North Downs, 17 per cent for Oaklands, and 4 per cent or less for each of the other five hospitals.

4.169. This approach avoids the danger of defining the catchment area too widely, but it has some limitations and appears to have produced some anomalies. The criteria used in the BUPA analysis for identifying an overlap area (a minimum 0.5 per cent of discharges and 20 per cent share each), although not apparently unreasonable, are arbitrarily chosen. The former criterion moreover has the drawback that where a hospital made discharges to 200 sectors, any sector that was below the average (0.5 per cent) would be excluded. Anomalous results are that several sectors near Berkshire Independent were recorded as non-overlap, but they were surrounded by overlap sectors. There was a similar result near North Downs. None of the sectors between Oaklands and BUPA Manchester were overlaps, but there were overlap areas on the other side of Oaklands (ie on the side away from BUPA Manchester).

### ***Definition of areas***

4.170. There is no single agreed definition of the 'catchment area' of a hospital: the appropriate measure depends on local conditions. As mentioned, the OFT defined it as the area within a 20-mile radius. The 1990 report concluded that 'most patients are likely to live within 15 to 20 miles of the hospitals in which they are treated'. BUPA told us that many catchment areas had a radius of less than 20 miles. It said that there was 'no formula for defining the area in which hospitals compete given the diverse range of factors that affect the degree of competition between private hospitals'. However, it told us that the most important factors determining their size were HA boundaries, consultant work patterns, and geography. BUPA, and several third parties, told us that a GP would tend to refer patients to consultants who worked in the GP's HA area, and that these consultants would generally treat patients in private hospitals within that area. BUPA said that as a result a private hospital's catchment area would generally be contained within the boundaries of one HA. In support of this, BUPA provided us with maps showing varying degrees of correspondence between HA boundaries and discharges from BUPA and CHG hospitals. However, we found (see paragraph 4.182) that, in several cases, the pattern of patient discharges

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<sup>1</sup>A postal sector is an area defined by the first four characters of the postcode. There are 9,000 postal sectors in the UK, which means the average size is 26 square kilometres. The size of postal sectors will vary depending on the population density of the area.

from CHG hospitals did not appear to correspond to the HA, particularly where the hospital was located close to the boundary of two HA areas.

4.171. The size of a catchment area also depends to some extent on the quality of its roads. We therefore considered catchment area definitions based on isochrones, ie the distance that could be travelled by car from a hospital in a particular time. Isochrone analysis has the advantage over radius measures of taking greater account of local conditions, but it is not obvious what is the most appropriate driving time to adopt and it could vary widely between hospitals. Analysis provided by BUPA found that on average 80 per cent of discharges from BUPA hospitals were within 36 minutes' drive, although there was a wide variation around that average. The average for CHG was 29 minutes. GHG told us that 80 per cent of discharges were within 30-minute drive for a normal independent hospital. We focused on isochrones of a 30 minutes, but in some cases a longer time might be more appropriate, particularly in rural areas.

4.172. BUPA told us that a definition of catchment areas based primarily on discharge data did not address the main competitive constraint—that of consultants' work patterns. It said that the choice of hospital was generally made by the consultant, rather than the patient, and that as a result the consultant was the central focus of local competition. We note that, as BUPA also told us, patient discharge patterns reflect the choices made by consultants. Similarly, BUPA questioned the use of isochrones on the grounds that, as patients did not choose the hospital, their distance from it would not influence the choice. Nevertheless, we note that driving distance is clearly an important consideration in determining, whether directly or indirectly, the hospital in which a patient is treated. Convenience of location is important to consultants as well as to patients, and consultants, particularly those regularly practising in more than one private hospital, may be expected to consider the convenience to their patients in choosing a hospital in which to treat them. Distance is also important from the viewpoint of the PMI provider seeking national coverage for its members, because prospective subscribers, before buying a policy, would want to know which of their local hospitals they would be able to use.

4.173. In summary, we thought the most appropriate definition of a hospital's catchment area was either the boundary of the relevant HA area or, where this did not sufficiently correspond to the pattern of patient discharges from the hospital, a 30-minute isochrone. In establishing which of these two definitions accounted for the greater proportion of discharges, we used home postcodes of patients (inpatient and day-case) discharged from each CHG hospital in 1999 (see paragraphs 4.182 and 4.183). We also used BUPA PMS's discharge data to identify the extent of overlap between CHG and BUPA in each area. However, as comprehensive discharge data were not available from all private hospitals, market share estimates (see paragraph 4.184) are based on discharges of BUPA PMI members from all private hospitals (excluding NHS PPU's) in 1999. BUPA members account for around 25 per cent of all private hospital patients (inpatients and day-cases), and this is therefore a large sample, relative to the size of the population. However, the sample is not random, and may lead to some overstatement of the shares of hospitals in the BUPA network.

4.174. In assessing whether one hospital competes with another we have also considered the extent to which individual consultants divide their work between hospitals. BUPA told us that in a competitive catchment area, consultants will transfer their work between hospitals, and that the proportion of work at each hospital will be broadly even. However, BUPA also told us that consultants are disinclined to divide their work between several hospitals. It appears that while the practice of consultants' sharing their private work between hospitals is common, there is nevertheless a tendency, overall, for consultants to carry on a majority of their private work in a single hospital.

4.175. BUPA has provided us with information, based on BUPA PMI data, on the proportion of their subscribers requiring hospital treatment that the key consultants<sup>1</sup> at each hospital admitted to that hospital in 1999/2000. (For example, if the key consultants for Hospital A together treated 800 patients at Hospital A, and these same consultants treated a total of 1,000 private patients at all hospitals, Hospital A's average share of key consultant admissions would be 80 per cent.) In 67 of the 139 hospitals owned by the four national PMS providers, the average share of key consultant admissions was more than 75 per cent, and across all 139 hospitals it was 70 per cent.

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<sup>1</sup>Key consultants are defined as those making at least five admissions to that hospital in the time period.

4.176. The share of key consultant admissions may provide some indication of the extent to which a hospital competes for consultants' work with others in the area. However, the preference of consultants to base themselves at one hospital may, in some cases, generate high concentrations irrespective of the proximity of other hospitals. In this light, competition for consultants' services may take the form of encouraging them to move most or all of their work from one hospital to another, rather than to divide their time between hospitals. Furthermore, in cases where consultants divide their work between hospitals, this may reflect a shortage of capacity at the hospitals used, suggesting complementarity rather than competition between hospitals. Nevertheless, we accept that very low levels of key consultant concentration (for example, 60 per cent, which is 15 per cent below average, or less) would tend to indicate a significant degree of competition, and very high levels (for example, 90 per cent or more) the likelihood of a solus position (see paragraph 4.178).

4.177. We note that private hospitals' discharge patterns, and therefore their catchment areas, are not necessarily static over time, and that they are often largely determined by a relatively small group of consultants. If a hospital is able to attract more work from these key local consultants, for example by investing in specialist facilities, its catchment area may change. As an extreme example, a hospital may be able to broaden its catchment area by becoming a flagship hospital. Indeed, discharge data can, in this light, be seen as records of the outcomes of competition between hospitals.

### ***Solus hospitals***

4.178. Hospitals which are the only providers of PMS services in their area are usually described as solus. (This does not of course imply that every patient living in the area attends that hospital.) BUPA told us that it found the concept of solus hospitals difficult to define meaningfully, because many consultants had in effect only one realistic choice of private hospital, and in that sense many hospitals could be described as solus. However, several third parties identified specific hospitals which they considered to be solus, and told us that ownership of solus hospitals strengthened a PMS provider's position in national price negotiations with PMI providers, who wished to offer national coverage to their subscribers. The OFT also expressed concern about the increase in solus hospitals that would be owned by BUPA as a result of the proposed merger. Where all the hospitals in an area are owned by the same group, an effective solus situation may be said to exist.

4.179. The local market features of the 21 CHG hospitals are considered in Tables 4.9 and 4.10. The assessment of how many CHG hospitals were solus varied widely: BUPA said that there was only one (although it also said that it 'thought the concept was nebulous'), but PPP said that there were 13. (Similarly, BUPA told us that only two of its own hospitals were solus, while PPP said that 13 of them were.) PPP defined a solus hospital as the only one in its catchment area, and defined catchment areas largely on the basis of the 1990 boundaries of HAs, of which there were 197 (a number which is close to the total of 216 private acute hospitals). However, PPP also told us that where terms could not be agreed with a solus hospital, another hospital in an adjacent catchment area could be a secondary source of supply. It told us that BUPA had hospitals in catchment areas adjacent to 19 of the 21 CHG hospitals. GHG named five CHG hospitals as solus: Duchy, Fitzwilliam, Mount Stuart, New Hall and Winfield.

4.180. Table 4.9 shows that there are wide differences in the views of BUPA, PPP and Norwich Union as to which CHG hospitals are solus. Table 4.10 presents an analysis of CHG solus hospitals, based on 30-minute isochrones. In the absence of the merger, two CHG hospitals, Duchy and New Hall, would have no other hospital within a 30-minute drive and, on that basis, could be considered as solus.

TABLE 4.9 CHG hospitals: local market features (1)

	Number of beds	Number of theatres	BUPA hospitals within 20 miles	Identified as solus hospital by:			
				BUPA	PPP*	Norwich Union†	
Ashtead (Surrey)‡	58	4	-	-	-	)	
Berkshire (Reading)‡§	71	3	Dunedin	-	-		
Duchy (Truro)	35	2	-	Yes	Yes		
Euxton Hall (Chorley)	24	1	Fylde Coast	-	Yes		
Fitzwilliam (Peterborough)	55	2	-	-	Yes		
Fulwood Hall (Preston)‡	31	2	Fylde Coast	-	Yes		
Mount Stuart (Torquay)	35	2	-	-	Yes		
New Hall (Salisbury)‡	34	2	Chalybeate	-	Yes		
North Downs (Surrey)‡§	24	1	Gatwick Park, Redwood, Tunbridge Wells	-	-		
Oaklands (Lancashire)‡§	24	2	Manchester, North Cheshire, Regency	-	-		
Oaks (Colchester)	57	2	-	-	Yes		
Park Hill (Doncaster)	22	1	-	-	Yes		
Pinehill (Hitchin)‡	33	3	Harpenden	-	Yes		≪
Renacres Hall (Ormskirk)	32	2	Fylde Coast, Wirral	-	-		
Rivers (Sawbridgeworth)‡	58	2	Hartwood, Roding	-	Yes		
Rowley Hall (Stafford)	15	1	-	-	-		
Springfield (Chelmsford)‡	64	5	Hartwood, Wellesley	-	Yes		
West Midlands (Halesowen)	34	2	Little Aston, Parkway, South Bank	-	Yes		
Winfield (Gloucester)	45	3	-	-	-		
Woodland (Kettering)	39	2	-	-	Yes		
Yorkshire Clinic (Bingley)‡	72	4	Leeds, Elland, Methley Park	-	-		

Source: CC, based on information from BUPA, CHG and third parties.

\*Viewed by PPP as the only hospital within its catchment area. PPP based its definition of catchment areas on the HA districts used before amalgamation at the start of the 1990s, modified slightly (to take into account the particular nature of the private sector) on the basis of where PPP members had been treated in the past.

†Viewed by Norwich Union as enjoying a monopoly position within its catchment area.

‡Identified by the OFT as raising competition concerns.

§BUPA recognized detriment to competition.

TABLE 4.10 CHG hospitals: local market features (2)

	<i>Number of private hospitals within 30 minutes' drive*</i>	<i>Number of non-BUPA and non-CHG private hospitals within 30 minutes' drive</i>	<i>CHG hospitals in possible solus situation post-merger</i>
Ashtead	14	11	-
Berkshire	8	7	-
Duchy	0	0	Yes
Euxton Hall	7	4	-
Fitzwilliam	1	1	-
Fulwood Hall	6	4	-
Mount Stuart	1	1	-
New Hall	1	0	Yes
North Downs	9	6	-
Oaklands	12	9	-
Oaks	3	2	-
Park Hill	2	1	-
Pinehill	5	4	-
Renacres Hall	4	3	-
Rivers	6	4	-
Rowley Hall	2	2	-
Springfield	4	1	-
West Midlands	7	6	-
Winfield	1	1	-
Woodland	2	1	-
Yorkshire Clinic	4	2	-

Source: CC.

\*Excluding named CHG hospital and PPU.

4.181. However, as discussed in paragraph 4.176, an exceptionally high share of key consultant admissions could also be an indicator of a solus position. We note, as shown in Table 4.12, that two CHG hospitals, Duchy and Mount Stuart, both have a key consultant admissions share of around 95 per cent and, on this basis, could be considered to be solus.

### ***BUPA/CHG overlap areas***

4.182. As discussed in paragraph 4.173, BUPA and CHG provided us with postcode data on all inpatients and day-cases discharged from their hospitals in 1999. Taking the CHG data first, we considered two different catchment area definitions: HA, and 30-minute drivetime isochrones. For each CHG hospital we measured the proportion of discharges that fell within each of these areas in 1999. The results are shown in the first two columns of Table 4.10. From Duchy, for example, 99 per cent of discharges fell within the HA (although the distribution showed that the District Health Authority did not delimit the local catchment area in all directions), while only 64 per cent were within a 30-minute drive. In contrast, only 32 per cent of discharges from Renacres Hall were within the HA area of the hospital, while 97 per cent were within a 30-minute drive.

4.183. In Table 4.10 the measure which covers the largest proportion of discharges from CHG<sup>1</sup> is boxed. However, the 30-minute isochrone is not preferred to the HA unless it accounts for at least 5 per cent more discharges (ie where the choice between the two is marginal, the HA is preferred). In most cases the preferred catchment definition accounted for 90 per cent or more of CHG discharges in 1999, but the figure was substantially below 90 per cent for two hospitals—New Hall (60 per cent) and Fitzwilliam (75 per cent)—suggesting that the true catchment area was wider than either the HA or the 30-minute isochrone. In five cases—Berkshire, Mount Stuart, Oaks, Springfield and Woodland—the HA was only marginally preferred as a catchment definition to the 30-minute isochrone. In the cases of Oaks and Springfield, as the catchment area for both is the HA area, and as both are in the same HA area, both effectively shared the same catchment area. Table 4.10 also shows BUPA hospitals with over 5 per cent share of BUPA and CHG discharges only in each area. These figures reflect the extent of overlap with individual BUPA hospitals, rather than market share, as other hospitals are not accounted for at this stage (but see Table 4.11 for our subsequent market share analysis).

<sup>1</sup>This may include discharges from CHG hospitals other than those named, including hospitals outside the area.

TABLE 4.11 Comparison of catchment areas of CHG hospitals and BUPA share of discharges within those areas

	% of CHG discharges within catchment area		BUPA hospitals with at least 5% share within catchment area*
	HA	30 minutes	
Ashtead	75	97	Gatwick Park (34%) Clare Park (19%)
Berkshire	92	93	Dunedin (54%)
Duchy†	99	64	-
Euxton Hall	52	96	Manchester (20%) North Cheshire (11%) Fylde Coast (7%)
Fitzwilliam	49	75	Cambridge Lea (11%)
Fulwood Hall	49	93	Fylde Coast (27%) Manchester (8%)
Mount Stuart†	98	96	-
New Hall‡	61	58	Bristol (13%) Chalybeate (8%)
North Downs	61	95	Gatwick Park (44%)
Oaklands	63	94	Manchester (43%) North Cheshire (29%)
Oaks	94	95	Roding (12%)
Park Hill	68	88	Leeds (30%) Hull & Exeter (6%)
Pinehill‡	70	98	Harpenden (54%)
Renacres Hall	32	97	Murrayfield Wirral (15%) North Cheshire (12%)
Rivers‡	46	95	Roding (29%) Harpenden (15%) Hartwood (8%)
Rowley Hall	84	92	Little Aston (65%)
Springfield	91	92	Roding (10%)
West Midlands	67	94	Little Aston (45%) Parkway (20%) South Bank (10%)
Winfield	92	83	Bristol (9%)
Woodland†	93	94	Leicester (10%)
Yorkshire Clinic	77	93	Leeds (28%) Elland (22%)

Source: CC, based on information from BUPA, CHG and third parties.

\*Based on selected (boxed) choice of preferred catchment area definition. The hospital itself may be outside the catchment area. Share (in parentheses) is of CHG and BUPA discharges only, ie the extent of overlap. Discharge data not available for six recently acquired BUPA hospitals: Methley Park, Redwood, Regency, Tunbridge Wells, Washington and Yale.

†Identified as possible CHG solus hospital in Table 4.10.

‡Identified as possible BUPA/CHG solus situation post-merger (Table 4.10).

4.184. Table 4.12 shows market shares, based on BUPA PMI discharge data (as discussed in paragraph 4.173), for the local catchment areas of each of the CHG hospitals. PPU's have been excluded

because of their limited competitive influence (see paragraph 4.16). These local catchment areas are as selected in Table 4.11. Table 4.12 also shows shares of key consultant admissions (see paragraph 4.175) for each of the CHG hospitals, and for BUPA hospitals in the same catchment area.

4.185. From Table 4.12, it appears that in five cases—those of Ashtead, New Hall, North Downs, Oaklands and West Midlands—the combined post-merger BUPA/CHG market share would be less than 40 per cent. (We note that New Hall, Oaklands and North Downs were identified as substantial overlap areas by the OFT.) In four of the remaining areas—Duchy, Mount Stuart, Winfield and Woodland—there is only limited overlap between BUPA and CHG, in that the share of one or other of them is less than 10 per cent. In the 11 remaining areas, there are prima facie grounds for considering that the proposed merger might lead to a reduction in competition, but there may be area-specific reasons why this would not be the case. We consider each of these areas in turn in Appendix 4.5, taking into account key consultant admissions in the hospitals concerned, specialities of individual hospitals, particular features of discharge patterns, the presence of other hospital groups in the area, and evidence from BUPA, CHG and third parties. We note that, in each of these areas, the combined share of BUPA and CHG would still have been over 40 per cent if PPU's had been included in the share calculations.

4.186. As mentioned, we consider 11 areas (treating Oaks/Springfield as a single area) in Appendix 4.5. In brief our assessment is as follows: we accept BUPA's argument, confirmed by CHG, as regards Fulwood Hall, that it does not (at present) substantially overlap with BUPA's Fylde Coast hospital, beyond a small range of specialities; in the cases of Yorkshire Clinic and Park Hill, the pattern of discharge data suggests that overlap between CHG and BUPA is limited to a small area; but in the remaining eight areas, accounting for nine CHG hospitals, the evidence points to a substantial overlap with BUPA and a large combined market share if the proposed merger were to go ahead. These hospitals are: Berkshire Independent, Euxton Hall, Renacres Hall, Fitzwilliam, Oaks/Springfield, Pinehill, Rivers and Rowley Hall.

4.187. In summary, then, the outcome of our local area analysis is that there is at least one area, and possibly two, where as a result of the proposed merger BUPA would gain a solus position. In eight areas the level of overlap between BUPA and CHG would be substantial, and their combined PMS market share would be large.

### ***Flagship hospitals***

4.188. The OFT identified a separate type of hospital that might be termed flagships, because they possessed an intensive care unit, and coronary care and major diagnostic facilities. Such hospitals tended to draw patients from a wider catchment area. GHG told us that BUPA had five flagship hospitals (Leeds, Leicester, Cambridge, Bristol and Chalybeate), CHG had one (Yorkshire Clinic), GHG had five and there were 19 others, only three of which were outside London.

4.189. However, BUPA, and several third parties including Norwich Union and WPA, told us that the idea of flagship hospitals was meaningless. They said that a hospital might draw from a wider catchment area if it specialized in a particular treatment, but not merely by offering an intensive care unit, coronary care and major diagnostic facilities. Norwich Union cited the example of BUPA Chalybeate which had a cardiac programme while Nuffield Wessex did not. The Chalybeate probably had a wider catchment area for cardiac treatment than Nuffield, but Nuffield Wessex had a hydrotherapy pool which widened its catchment area for orthopaedics. It appears, therefore, that flagship status of a hospital could depend on the treatment required.

### ***Wider areas***

4.190. There is also some concern about wider areas, where several CHG and, in some cases, BUPA hospitals are grouped together, while other hospital groups have a limited presence. The areas of concern are North Essex/Hertfordshire (including Oaks/Springfield, Pinehill and Rivers), Lancashire (Euxton Hall, Renacres Hall and possibly Fulwood Hall), Leicester (Fitzwilliam, possibly Woodlands, and also CHG's Fotheringay Suite and BUPA Leicester), and Leeds/Bradford (possibly Yorkshire Clinic, with BUPA Leeds and BUPA Elland, all three of which may be described as flagship hospitals although, as mentioned above, overlap between Yorkshire Clinic and BUPA hospitals appears limited).

TABLE 4.12 CHG hospitals: shares of patient discharges and key consultant admissions

	% share of private hospital discharges (excluding NHS)						Share of key consultant admissions*		
	BUPA	CHG	BUPA+CHG	BMI	Nuffield	Others	CHG hospital	BUPA hospitals with share in catchment area†	BUPA hospital
Ashtead	14	8	<b>22</b>	18	13	46	66	Gatwick Park	83
Berkshire	34	12	<b>45</b>	25	20	10	41	Clare Park	74
Duchy	0	69	<b>69</b>	2	27	2	94	Dunedin	73
Euxton Hall	22	30	<b>52</b>	35	1	12	68	Manchester	75
Fitzwilliam	13	66	<b>79</b>	2	2	17	84	North Cheshire	81
Fulwood Hall	21	33	<b>54</b>	35	3	9	62	Fylde Coast	88
Mount Stuart	1		<b>46</b>	1	52	2	97	Cambridge Lea	54
New Hall	4		<b>24</b>	67	4	4	86	Fylde Coast	88
North Downs	16		<b>28</b>	30	10	32	16	Manchester	75
Oaklands	29		<b>36</b>	51	3	11	42	Manchester	75
Oaks } Springfield } Park Hill }	12	60	<b>72</b>	5	5	18	{ 85 } 86 } 85 }	North Cheshire	81
Pinehill	43	15	<b>58</b>	17	3	22		Roding	59
Renacres Hall	14	36	<b>50</b>	4	1	44		Leeds	84
Rivers	33	20	<b>53</b>	16	10	21	73	Hull & East Riding	79
Rowley Hall	32	13	<b>45</b>	18	37	0	79	Harpenden	64
West Midlands	30	7	<b>37</b>	45	18	0	79	Wirral Murrayfield	68
Winfield	7	40	<b>47</b>	8	38	7	54	North Cheshire	81
Woodland	8	39	<b>47</b>	43	2	8		Roding	59
Yorkshire Clinic	44	34	<b>78</b>	2	18	2	76	Harpenden	64
							76	Hartswood	45
								Little Aston	50
								Little Aston	50
								Parkway	60
								South Bank	87
							79	Bristol	70
							78	Leicester	76
							87	Elland	86
								Leeds	84

Source: CC, based on data provided by BUPA.

\*June 1999 to May 2000.

†From Table 4.10.