

## **PRIVATE HEALTHCARE MARKET INVESTIGATION**

### **Provisional decision on remedies**

Notified: 16 January 2014

The Competition Commission has excluded from this published version of the provisional decision on remedies information which the inquiry group considers should be excluded having regard to the three considerations set out in section 244 of the Enterprise Act 2002 (specified information: considerations relevant to disclosure). The omissions are indicated by [X].

## Contents

	<i>Page</i>
Summary .....	1
Provisional decision on remedies .....	1-1
1. Introduction .....	1-1
The provisional findings .....	1-3
Framework for the assessment of remedies .....	1-4
2. Remedy measures that we are proposing to take forward .....	2-1
Remedy 1: Divestiture remedy .....	2-1
Introduction .....	2-1
Aim of remedy .....	2-3
Views of parties .....	2-3
Design issues and effectiveness assessment .....	2-21
The proposed divestitures .....	2-38
Divestiture locations .....	2-40
Conclusions on proportionality .....	2-63
Conclusion on divestiture remedy .....	2-66
Remedy 3: restrictions on expansion .....	2-67
Introduction .....	2-67
How the remedy would address the AEC .....	2-69
What parties told us .....	2-69
Assessment .....	2-81
Proportionality .....	2-92
Conclusions on proportionality .....	2-93
Conclusions on Remedy 3 .....	2-93
Remedy 4: Clinician incentives .....	2-94
Introduction .....	2-94
Provisional findings on clinician incentives .....	2-95
Our proposed remedy .....	2-97
Approaches to clinician incentives in other jurisdictions .....	2-118
Regulatory environment in the UK .....	2-120
Assessment .....	2-123
Design considerations .....	2-127
Oversight .....	2-134
Conclusions on effectiveness .....	2-134
Proportionality .....	2-135
Conclusions on proportionality .....	2-137
Conclusions on Remedy 4 .....	2-137
Remedies 5–7: Information on consultant and hospital performance .....	2-138
Introduction .....	2-138
Consultant performance information .....	2-139
Private hospital performance information .....	2-149
Assessment of performance information remedies .....	2-159
Conclusions on effectiveness .....	2-167
Proportionality .....	2-170
Information on consultant fees .....	2-173
Assessment .....	2-181
Modified Remedy 6 .....	2-183
Effectiveness .....	2-186
Proportionality .....	2-187
3. Remedies we do not intend to pursue .....	3-1
Introduction .....	3-1
Remedies contained in our Remedies Notice .....	3-1
Remedy 2 (constraints on private medical insurer/private healthcare provider contract terms ('tying and bundling')) .....	3-1

Remedy 8 (price controls).....	3-27
Other remedy proposals.....	3-29
Background .....	3-29
4. The proposed package of remedies: effectiveness and proportionality.....	4-1
Introduction .....	4-1
How the proposed package of remedies addresses the AEC.....	4-3
Contribution of individual elements of the remedy package .....	4-3
Synergies between remedies .....	4-5
Conclusion on how the proposed remedy package addresses the AEC .....	4-6
The effectiveness of the remedies package .....	4-7
Implementation, monitoring and enforcement.....	4-7
Timescale over which our remedies will have effect .....	4-8
Consistency with other regulatory regimes .....	4-10
Coherence as a package.....	4-11
Conclusion on effectiveness of remedy package .....	4-11
Relevant customer benefits.....	4-12
Assessment of proportionality .....	4-12
Is the remedy package effective in achieving its aim? .....	4-13
Is the remedy package no more onerous than is necessary to achieve its aim? ...	4-13
If there is a choice of remedy packages, is this the least onerous?.....	4-14
Does the remedy package produce adverse effects which are disproportionate to the aim? .....	4-14
Conclusions on proportionality of remedies package .....	4-15
Conclusions on the remedy package .....	4-15

## Appendices

2.1	Divestitures in central London
2.2	Consideration of divestiture remedies outside central London
2.3	Divestiture remedies—views of the parties
2.4	Methodology for identifying ‘clusters’ of private hospitals
2.5	Quantifying the price benefits of divestitures
2.6	[REDACTED]
2.7	Approaches to clinician incentives in other jurisdictions
2.8	BUPA’s proposed basic safety indicators
2.9	WPA consultant fees template letter

## Summary

1. This document presents our provisional decision on the package of remedies required to remedy the adverse effects on competition (AECs) and resulting customer detriment that we have provisionally found. The provisional decision on remedies and its accompanying appendices provide a basis for further consultation. We invite views in writing on this provisional decision on remedies by 5pm on 6 February 2014. A small number of parties have been asked to attend a meeting with the CC following this deadline.
2. Our provisional decision on remedies is based on our provisional findings which were published in summary form on 28 August 2013 and in full on 2 September 2013. These found that there were structural and conduct features which on their own and in combination gave rise to AECs in the provision of privately-funded healthcare services in the UK. The two structural features we identified were: (a) high barriers to entry and expansion for full service hospitals and (b) weak competitive constraints in many local areas including central London. We considered that together these two structural features led to higher prices for self-pay patients in certain local markets and to higher prices for insured patients for treatment by those hospital operators (HCA, BMI and Spire) that have market power in negotiations with private medical insurers. In addition, we found conduct features that give rise to AECs, namely the operation of incentive schemes by private hospital operators to encourage patient referrals by clinicians, a lack of sufficient information on the performance of private hospitals and a lack of information on the performance and fees of consultants. In the provisional findings, the customer detriment caused by the market power of HCA, BMI and Spire was conservatively estimated within a range of £173 million to £193 million a year between 2009 and 2011.

3. The provisional decision on remedies takes account of our consideration of the evidence we have received from written responses to our Notice of possible remedies (Remedies Notice) which was published on 28 August 2013, our divestment options paper which was provided to the five largest hospital groups and three largest private medical insurers, response hearings with parties to this investigation, and their further submissions of evidence.
4. We have not, at this stage, made a final decision regarding the existence and form of any AEC and/or resulting customer detriment. Our provisional decision on remedies therefore proposes remedies that address the AECs as set out in our provisional findings with the exception that we have reviewed the applicability of the AECs to local markets where divestiture was proposed in our Remedies Notice in the light of parties' submissions and further analysis. Our final decision on any AECs, and appropriate remedies, will take into account all evidence received and submissions made including the responses to our provisional findings and provisional decision on remedies.
5. We have provisionally decided on a package of remedies that consists of five elements: (a) divestiture of nine private hospitals;<sup>1</sup> (b) review by the OFT/CMA of arrangements under which private hospital operators enter into agreements to operate private patient units (PPUs) in NHS hospitals and prohibition of such arrangements if they fail a competition test; (c) prohibition of or restrictions on certain clinician incentive schemes that encourage patient referrals to particular facilities or for particular treatments or tests; (d) requiring the collection and publication of information on the performance of private hospitals and individual consultants; and (e) requiring that private hospital operators include as a condition of granting

---

<sup>1</sup> We take 'hospital' to mean the assets that a new owner of the hospital would need in order to compete with the retained business.

practising privileges an obligation on consultants to provide fee information to patients using standard letter templates and that private hospital operators ensure that consultants comply with the obligation.

6. The elements of the remedies package work together in a complementary manner to address the AECs. The proposed divestitures will directly introduce greater rivalry in local markets where a private hospital operator currently controls a cluster<sup>2</sup> of hospitals that are subject to weak competitive constraints. By increasing choice for both self-pay patients and private medical insurers, divestiture would increase competition between operators on both price and quality. Reviewing arrangements under which PPUs contract with private hospital operators to operate PPUs would, where appropriate, restrict existing private hospital operators facing weak competitive constraints in the relevant local area from operating such PPUs, thus facilitating new entry into such areas or expansion by other existing operators. The prohibitions of and restrictions on clinician incentive schemes seek to prevent distortions in competition where these incentive schemes might introduce non-clinical considerations into treatment and hospital choices. The information remedies would address the AECs, with growing impact over time, by facilitating patient choice on the basis of quality and price and stimulating private hospital operators and consultants to compete for patients on the basis of objective quality criteria and also on price.

7. We summarize the elements of the proposed remedies package in further detail below:

*(a) Divestiture of hospitals*

We propose that HCA should divest two hospitals in central London (London Bridge and Princess Grace) and that BMI should divest seven hospitals in various

---

<sup>2</sup> Areas identified by the CC as areas in which a private hospital operator operates more than one hospital and is subject to weak competitive constraints in that area.

local markets across England (either Bishops Wood or Clementine Churchill, either Cavell or Kings Oak, either Shelburne or Chiltern, Chelsfield Park and either Sloane or Shirley Oaks, either Saxon Clinic or Three Shires, and Highfield). These divestitures would introduce greater rivalry in some major population centres and areas of high private health insurance penetration, in particular central and Greater London, the Home Counties to the north, north-west and south-east of London and part of the North-West of England. In central London we consider that the proposed divestitures would enable substantially greater rivalry on price and will enhance rivalry on quality and innovation. Outside central London we envisage that the structural changes arising from the divestitures, though smaller in scale, would also result in greater rivalry, bringing benefits to customers in terms of price, quality and innovation.

Divestiture would take place to suitable purchasers that are independent of the divesting parties and have appropriate financial resources, expertise and assets to enable the divested hospitals to be effective competitors in their respective markets. Appropriate expertise would include expertise and experience in operating hospitals of a level of acuity and specialism appropriate to the hospitals being divested. We would require commitments from the divesting hospital groups not to induce consultants to move their practice to the group's retained facilities, that private medical insurers continue to recognize on the same terms the divested hospitals for a period, and we would require the appointment of a monitoring trustee to oversee the divestiture process and compliance with divestiture commitments. We would reserve the right to appoint a divestiture trustee should divestiture not be implemented within the specified divestiture period.

*(b) Review of PPU arrangements with private hospital operators*

This remedy would require proposed transactions between NHS Trusts and private hospital operators for the operation of a PPU to be evaluated on a case

by case basis on their merits. We found that PPUs can offer a lower-risk means of market entry or expansion for private hospital operators and that the number of PPUs is likely to increase as a result of the lifting of the cap on the amount of private income an NHS Trust could earn as a result of the Health and Social Care Act 2012. Under the proposed order, the OFT/CMA would be able to review arrangements under either existing merger control provisions if it is a relevant merger situation as currently or under the provisions set out in the order. Parties to such arrangements would be required to notify all such arrangements and, if the arrangements do not create a merger situation, the OFT/CMA would assess the arrangements applying a competition test equivalent to the significant lessening of competition test under the UK merger control regime. Arrangements which failed the competition test would be prohibited. The power to prohibit such arrangements where merger control would not apply will address the AECs by restricting existing private hospital operators facing weak competitive constraints in the relevant local area from operating such PPUs. This will facilitate new entry and expansion by other private hospital operators in the relevant local area thereby increasing the competitive constraints on the incumbent.

*(c) Prohibition and restrictions on clinician incentive schemes*

This measure would take the form of an order prohibiting private hospital operators from providing direct incentives to clinicians which encourage clinicians to treat patients at or commission treatments or tests from their hospitals. It will also place restrictions on equity sharing arrangements between private hospital operators and clinicians. We also propose that private hospital operators disclose publicly via their websites the nature and market value of services provided to clinicians, any payments made to clinicians in return for services<sup>3</sup> and details of

---

<sup>3</sup> Other than services provided to patients directly, for example where the hospital reimburses a consultant his/her fee from a packaged patient fee.



any clinicians practising at their hospitals who own equity in any of their facilities including in equipment.

These requirements are aimed at ensuring that competition between private hospital operators for patients is on the basis of quality and price of the healthcare services they offer rather than the value of inducements paid to clinicians to encourage referrals whilst also maintaining the customer benefits associated with clinicians' engagement through equity participation. They would also make transparent to patients, other clinicians and private medical insurers, the means by which private hospitals compete for clinicians.

*(d) Publishing information on hospital and consultant performance*

This measure would require private hospital operators and private medical insurers to fund jointly an information organization to collect and publish information with prescribed content and format on the performance of hospitals and individual consultants. Increasing the availability of performance information would enable patients, other clinicians and private medical insurers to make meaningful choices between providers and stimulate competition between private hospital operators and between consultants.

*(e) Providing consultant fee information*

Under this remedy, private hospitals operators would require, as a condition of practising at their facilities, that all consultants provide fee information to patients in a standard prescribed format. In the longer run, consultants would be required to provide information to the information organisation on their fees for publication on its website. The remedy would address the AEC by increasing all patients' awareness of fees (whether insured or self-pay) and facilitate more effective choices by patients and others involved in a patient's referral pathway between consultants. In combination with the remedy on consultant performance information, this would allow patients to choose a consultant who offers the best value healthcare, thus stimulating competition to attract patients.

8. Following consideration of parties' responses to the Remedies Notice and our own further analysis, we have also decided not to proceed with particular remedies outlined in our Remedies Notice regarding preventing tying or bundling by hospital operators and imposing price controls on hospital operators.
9. We have provisionally concluded that our proposed package of remedies is capable of effective implementation, monitoring and enforcement and that the package of remedies will have a substantial effect on the AECs in the short term and this effect will grow in the longer term.
10. We consider that our proposed package of remedies represents as comprehensive a solution as is reasonable and practicable to the AECs. Our package of remedies would address the AECs by reducing local concentration through divestitures, facilitating entry and expansion through PPUs and enabling rivalry between private hospitals and between consultants on the basis of the price and quality of services provided to patients rather than, for example, the benefits they provide to clinicians or referral patterns based on inadequate price and/or performance information.
11. Individual remedies should not be viewed in isolation but as part of a complementary package of remedies to address the AECs. Our information remedies work together with our structural remedies by providing patients and others involved in the referral pathway with adequate information on performance and price to enable patients and others effectively to weigh price and, for example, travel time against quality. The PPU remedy will assist in increasing the competitive constraints on existing private hospital operators in any local areas where an NHS Trust wishes to partner with a private hospital operator to operate a PPU. Without the remedy on clinician incentives, the PPU remedy (and the divestment remedy) might be frustrated through the use of incentives to retain in particular consultants.

12. We have provisionally concluded that our proposed remedies package would not result in any material reduction in any relevant customer benefits that might accrue from the features that give rise to the AECs. In relation to the proportionality of our proposed package of remedies, we have provisionally concluded that, having evaluated the prospective benefits and costs of these measures, the beneficial effects of the package of remedies are likely to outweigh significantly the costs of the measures. We also consider that the package is no more onerous than is necessary to achieve its aim and is the least onerous remedy package that is likely to be substantially effective.
13. In view of the above, we have therefore provisionally concluded that our proposed package of remedies represents as comprehensive a solution as is reasonable and practicable to the AECs and resulting customer detriment that we have provisionally found.

## **Provisional decision on remedies**

### **1. Introduction**

- 1.1 On 4 April 2012, the Office of Fair Trading (OFT) referred the supply or acquisition of private healthcare in the UK to the Competition Commission (CC) for investigation. In our provisional findings, a summary of which was published on 28 August 2013 and a non-confidential version of which was published on 2 September 2013, we provisionally found that there are features of the markets for the supply of private healthcare services that result in an adverse effect on competition (AEC<sup>4</sup>) within the meaning of section 134(2) of the Enterprise Act 2002 (the Enterprise Act).
- 1.2 Where the CC finds that there is an AEC, it has a duty, under the Enterprise Act, to decide whether action should be taken by the CC, or recommended for others, to remedy, mitigate or prevent the AEC and any detrimental effects on customers resulting from it. The CC must also decide what action should be taken and what is to be remedied, mitigated or prevented. In taking this decision, the CC, as required by the Enterprise Act, will seek to achieve as comprehensive a solution as is reasonable and practical.
- 1.3 We published a Notice of possible remedies (the Remedies Notice) with the provisional findings on 28 August 2013. This set out a number of measures that we considered could address the AECs and the resulting detrimental effects and invited comments from all interested parties. We received a number of responses to our Remedies Notice and have held several response hearings and meetings with relevant parties. Non-confidential versions of such responses and summaries of response hearings held can be found on our website.

---

<sup>4</sup> AEC refers to one or more adverse effect on competition.

- 1.4 Following publication of the Remedies Notice, as set out in paragraph 26 of the Remedies Notice, we also consulted the five largest hospital groups and the three largest insurers on our preliminary analysis<sup>5</sup> of which hospitals may be divested based on our proposed approach to the identification of areas in which divestment may be appropriate as set out in the Appendix to the Remedies Notice.
- 1.5 Having given careful consideration to all the evidence we have gathered including the submissions received in response to the Remedies Notice, the Divestment Options paper and in the response hearings, this document sets out our provisional decision on remedies and serves as a basis for further consultation.
- 1.6 We have not, at this stage, made a final decision regarding the existence and form of any AEC and/or resulting customer detriment. Our provisional decision therefore proposes remedies that address the AECs as set out in our provisional findings with the exception that we have reviewed the applicability of the AEC to local markets where divestiture was proposed in our Remedies Notice in the light of parties' submissions and further analysis. Our final decision on any AEC, and appropriate remedies, will take into account all evidence received and submissions made including the responses to our provisional findings and provisional decision on remedies.
- 1.7 This document begins by summarizing the AEC set out in our provisional findings. It then sets out the framework we have used for consideration of remedies and the package of remedies we believe would be effective and proportionate in addressing the AECs and any detrimental effect on customers resulting from the AECs. Our consideration of each of the remedies comprising our proposed package of remedies broadly follows the same structure as the Remedies Notice, addressing in turn the

---

<sup>5</sup> This analysis was set out in our Divestment Options Paper, provided to these parties on a confidential basis.

remedies that we initially proposed (with the exception of the remedy on tying and bundling which we are no longer considering implementing) as follows: divestment (Remedy 1); restriction on expansion via agreements with NHS Trusts (Remedy 3); restriction on clinician incentives (Remedy 4); information on performance of consultants and hospital operators (Remedy 5 and Remedy 7); and information on consultant fees (Remedy 6). For each remedy we consider how the remedy will address the AEC and set out the views of parties. We then assess considerations regarding design and implementation before assessing and concluding on effectiveness and proportionality. We next consider those remedies that we are not minded to pursue including the proposed Remedy 2 on tying and bundling considered in the Remedies Notice, setting out our reasoning. Finally, we consider how the overall package of remedies will address the AEC, its likely effectiveness and its proportionality.

- 1.8 The private hospital operators and any other interested parties should provide any views on the analysis and conclusions in this provisional decision in writing no later than 6 February 2014. A small number of key parties likely to be materially affected by the proposed remedies package have been invited to also attend a hearing.

### ***The provisional findings***

- 1.9 Our current view, as set out in our provisional findings published on 28 August 2013, is that a number of features, both structural and conduct, on their own and in combination give rise to AECs in the provision of privately funded healthcare services in the UK. The structural features are:
- (a) high barriers to entry for full service hospitals; and
  - (b) weak competitive constraints in many local markets including central London.
- 1.10 Together these structural features give rise to AECs in the markets for hospital services, leading to higher prices for self-pay patients in certain local markets and to

higher prices for insured patients for treatment by those hospital operators (HCA, BMI and to a lesser extent Spire) that have market power in negotiations with insurers.

1.11 The conduct features that we consider give rise to an AEC are:

- (a) the operation of incentive schemes by private hospital operators to encourage patient referrals for treatment at their facilities, which gives rise to an AEC due to the distortion of referral decisions to particular hospitals and the distortion of patient choice of diagnosis and treatment options;
- (b) the lack of sufficient, publicly-available performance information on private hospitals, which gives rise to an AEC due to the distortion of competition between private hospital operators by preventing patients from exercising effective choice in selecting the private hospitals at which to be treated. This reduces competition between private hospital operators on the basis of quality and price; and
- (c) the lack of sufficient publicly available performance and fee information on consultants, which gives rise to an AEC due to the distortion of competition between consultants by preventing patients from exercising effective choice in selecting the consultants by whom to be diagnosed and treated. This reduces competition between consultants on the basis of quality and price.

### ***Framework for the assessment of remedies***

1.12 Having identified in our provisional findings a number of features of the markets for private healthcare services in the UK that give rise to the AECs, we are required to decide the following additional questions:<sup>6</sup>

- (a) whether action should be taken by the CC for the purpose of remedying, mitigating or preventing the AEC concerned or any detrimental effect on customers so far as it has, or may be expected to result from, the AEC;

---

<sup>6</sup> The Enterprise Act, section 134(4).

- (b) whether the CC should recommend the taking of action by others for the purpose outlined in paragraph 1.12) above; and
- (c) in either case, if action should be taken, what action should be taken and what is to be remedied, mitigated or prevented.

1.13 A detrimental effect on customers includes such an effect on future customers and is defined as one taking the form of:<sup>7</sup>

- (a) higher prices, lower quality, or less choice of goods or services in any market in the UK (whether or not the market to which the feature or features concerned relate); or
- (b) less innovation in relation to such goods and services.

1.14 In choosing appropriate remedial action, the CC has a statutory obligation to achieve as comprehensive a solution to the AEC and any detrimental effect on customers resulting therefrom as is reasonable and practicable.<sup>8</sup> The CC generally prefers to address the *causes* of the AEC directly, however, where this is not possible, or as an interim solution, the CC may introduce measures to mitigate the harm to customers created by the AEC.<sup>9</sup>

1.15 In practice, the CC may decide to take several discrete actions itself and/or make several discrete recommendations. This combination of measures is referred to as a package of remedies. In deciding what remedy or remedies would be appropriate, the CC will first look for a remedy that would be effective in achieving its aims. The CC has made several general observations in its guidance about factors relevant to its consideration of effectiveness.<sup>10</sup> First, a remedy should be capable of effective implementation, monitoring and enforcement. The effectiveness of any remedy may

---

<sup>7</sup> Section 134(5).

<sup>8</sup> The Enterprise Act, section 134(6).

<sup>9</sup> CC3, *Guidelines for market investigations: Their role, procedures, assessment and remedies*, April 2013, paragraph 333.

<sup>10</sup> CC3, paragraphs 334–341.



be reduced if elaborate monitoring and compliance programmes are required.

Second, the CC will take into account the time period over which a remedy is likely to have effect, including how quickly the remedy will take effect and the expected duration of the AEC that the remedy is designed to address. A third consideration is the way in which remedies will interact with each other and with any other existing or expected regulation of the relevant market.

- 1.16 In considering the reasonableness of different remedy options, the CC will have regard to their proportionality. In making an assessment of proportionality, the CC is guided by the following principles. A proportionate remedy is one that:<sup>11</sup>
- (a) is effective in achieving its legitimate aim;
  - (b) is no more onerous than needed to achieve its aim;
  - (c) is the least onerous if there is a choice between several effective measures; and
  - (d) does not produce disadvantages which are disproportionate to the aim.
- 1.17 In reaching a judgement about whether to implement a particular remedy, the CC will consider its potential effects on those persons most likely to be affected by it, generally customers and the businesses subject to the remedies. The CC will seek to quantify the costs and benefits associated with a remedy where it is reasonably practical to do so, taking into account any relevant customer benefits (RCBs) arising from the adverse feature or features of the market concerned. As set out in the Guidance,<sup>12</sup> RCBs are limited to benefits to relevant customers that take the form of:
- (a) lower prices, higher quality or greater choice of goods or services in any market in the UK (whether or not the market to which the feature(s) concerned relate); or
  - (b) greater innovation in relation to such goods or services.

---

<sup>11</sup> CC3, paragraph 344.

<sup>12</sup> CC3, paragraphs 355–359.

## **2. Remedy measures that we are proposing to take forward**

### ***Remedy 1: Divestiture remedy***

#### *Introduction*

- 2.1 We provisionally found that the combination of weak competitive constraints in many local markets and high barriers to entry for full service hospitals was likely to lead to higher prices for self-pay patients in certain local markets and to higher prices for insured patients for treatment by those hospital operators (HCA, BMI and to a lesser extent Spire) that have market power in negotiations with insurers.
- 2.2 At the time of our provisional findings we identified<sup>13</sup> a number of geographic areas throughout the UK in which we considered that divestitures may be an effective remedy for the lack of competitive constraints that we identified as giving rise to an AEC in the market for private healthcare services.<sup>14</sup> In these areas, individual private hospital operators had both high market shares and owned two or more facilities. In areas where hospital operators had high market shares but only owned one facility (ie Single or Duopoly areas<sup>15</sup>), we did not consider that divestiture would be an effective remedy to the AEC identified since the sale of a hospital would simply transfer market power from one operator to another.<sup>16</sup>
- 2.3 The areas where divestitures were considered as potentially appropriate at the time of the provisional findings were as follows:

---

<sup>13</sup> These areas were not published alongside our [provisional findings](#).

<sup>14</sup> The CC considered that the high barriers to entry were intrinsic to the market and could not be directly addressed via remedies. However, Remedy 3 seeks to facilitate new entry into local areas where we have identified hospitals with market power.

<sup>15</sup> As defined in paragraph 24 of the Remedies Notice. Note that, for these purposes, “Duopoly” areas include those with more than two hospitals all of which are run by different operators.

<sup>16</sup> This does not in any way reflect a view that market power in such areas prevents, restricts or distorts competition to a lesser extent than in areas where there are ‘clusters’ of co-owned hospitals but only that divestitures can be effective in reducing market power in the latter case and not in the former.

TABLE 1 Hospitals considered for divestiture by the CC\*

<i>Local area</i>	<i>Hospital operator</i>	<i>Hospitals in the cluster</i>	<i>Proposed divestitures</i>
Central London	HCA	Wellington, Princess Grace, London Bridge, Harley Street Clinic, Lister, Portland, NHS UCLH, LOC	London Bridge and Princess Grace
Greater London (north-west)	BMI	Bishops Wood and Clementine Churchill	Either Bishops Wood or Clementine Churchill
Greater London (north-west)	BMI	Chiltern and Shelburne	Either Chiltern or Shelburne
Greater London (north)	BMI	Cavell and Kings Oak	Either Cavell or Kings Oak
Greater London (south-east)	BMI	Blackheath, Sloane, Shirley Oaks, Chelsfield Park and Fawkham Manor	Chelsfield Park and Sloane
Greater London (south-west)	BMI	Runnymede, Princess Margaret and Mount Alvernia	Either Runnymede or (both) Princess Margaret and Mount Alvernia
Midlands (Birmingham)	BMI	Priory, Edgbaston, Droitwich Spa, Meriden	Either Priory or (both) Edgbaston and Droitwich Spa
Midlands (Milton Keynes/ Northampton)	BMI	Three Shires, Saxon Clinic, Manor	Saxon Clinic
North-West (Manchester)	BMI	Gisburne Park, Beardwood, Beaumont, Highfield and Alexandra	Beardwood and Highfield
North-West (Liverpool)	Spire	Liverpool, Wirral and Cheshire	None
Yorkshire	Spire	Leeds, Methley Park and Elland	Either Leeds or Methley Park and Elland
Lincoln	BMI	Lincoln and Park	None
Essex	Ramsay	Rivers, Springfield and Oaks	None
Scotland	BMI	Carrick Glen, Ross Hall and King's Park	None

Source: CC.

---

\*As noted above, we considered whether hospitals in these areas should be divested in order to remedy the AEC identified in these areas in our provisional findings.

2.4 An amended list following consideration of parties' submissions and further analysis is set out in Table 2 following paragraph 2.99.

2.5 In this section of the PDR we first consider how the divestiture remedy addresses the AEC and then summarize the views of the parties in response to our Remedies Notice. In the light of parties' views we set out the factors that we have considered in designing the divestiture remedies, including our conclusions regarding the likely effectiveness of divestiture in each local area of concern.<sup>17</sup> Finally, we assess the

---

<sup>17</sup> Our detailed analysis of each area is set out in Appendices 2.1 & 2.2 (central London and outside London area by area).

likely costs and benefits of divestitures before concluding on the likely effectiveness and proportionality of the divestiture package.

### *Aim of remedy*

- 2.6 The remedy would address the AEC arising from the structural feature of weak competitive constraints directly by introducing one or more additional competitors into local markets or strengthening existing competitors with a minor local presence. By increasing choice for both self-pay patients and insurers, divestiture should increase competition between operators on price and quality.
- 2.7 In the Remedies Notice, we asked parties for their views on whether divestiture would effectively and comprehensively address the AEC, whether the criteria used by the CC for specifying the divestitures were appropriate, whether there were likely to be suitable purchasers for the divested assets, what timeframe it would be appropriate to allow for divestitures to be completed and what the relevant costs and benefits of divestiture would be.

### *Views of parties*

- 2.8 We received extensive responses from both the private hospital operators and the insurers regarding our proposed divestiture remedies. In many cases, these responses focused on our provisional findings, with the private hospital operators arguing that there was no evidence to support the CC's finding of an AEC arising from weak competitive constraints in local markets. We have not at this stage made a final decision regarding the existence and form of any AEC and/or resulting customer detriment. We have based our provisional decision on remedies on our provisional findings, with the remedies set out here designed to address the AECs that the provisional findings identified. However, we have reviewed the applicability of AECs to the local markets in which we are considering divestitures based on parties' views

and further research and analysis. We summarize the changes to our views in paragraph 2.95 below. In this section we do not set out all the arguments made by the parties in relation to our provisional findings but focus on the responses that specifically address the design, effectiveness and proportionality of our proposed remedies. Our final decision on any AEC, and appropriate remedies, will take into account the responses to our provisional findings as well as responses to this provisional decision on remedies.

2.9 An extensive summary of the parties' responses is set out in Appendices 2.1, 2.2 and 2.3. In the following section, we summarize their main arguments regarding the design, effectiveness and proportionality of the divestiture remedies set out in our Remedies Notice.

- *Hospital operators*

- *HCA*

2.10 HCA put forward the view that the CC's proposed divestiture package would be ineffective in reducing prices to patients because:

(a) The substantial fixed costs incurred in operating its high acuity hospitals would not permit a purchaser to replicate HCA's services and charge a lower price.

Without the synergies of the services offered by the HCA network, a new entrant would struggle to replicate the same level of efficiency and quality and may have in some cases to raise its prices.

(b) The two hospitals provisionally earmarked for divestiture each offered several services not provided elsewhere in the HCA network: London Bridge [X] and Princess Grace [X]. Therefore, divestiture would not create a new competitor for the treatments or specialized services currently provided by the two hospitals.

(c) The two hospitals were not stand-alone, autonomous businesses which could easily be separated without damaging HCA's hospital network benefits and divestment would therefore lead to increased costs.

(d) The CC could not be confident that the insurers would pass on any price benefits that did occur to patients and indeed the evidence indicated that they would not.

2.11 HCA told the CC that by requiring it to divest of one or more of its hospitals, the divested hospitals and HCA's remaining hospitals would suffer a number of detriments, including with regard to the range of services, level of quality and overall level investment. HCA would also be deprived of various economies of scale and scope, such as, among other things, its centralized IT systems, clinical support services (such as HCA laboratories and patient medical record management), staff management, and a range of central support services such as procurement and business development. HCA estimated that the loss of economies of scale alone (and without taking account of other economic losses) would lead to at least a [X] per cent increase in average costs per patient at HCA's remaining facilities. HCA also submitted that there would be a range of one-off transaction costs that substantially increased the cost of divestment as well as work to 'untangle' the hospitals from HCA's wider network, which would not be straightforward.

2.12 In addition, HCA argued that there were a number of RCBs that the CC should take into account in considering the proportionality of its divestiture remedy. The loss of RCBs included (as set out in section 134 of the Act) lower quality, lower innovation, less choice for consumers and the potential loss of high acuity services in London as competitors might not be able, or might choose not to follow HCA's high-acuity, high-investment strategy, and HCA itself, deprived of its high patient volumes, may no longer be able to offer the same level of specialist expertise to patients. HCA said that, as a result, divestiture could have profoundly serious consequences for the

health and well-being of patients. We discuss these arguments more fully in Appendix 2.1 on central London divestitures where we discuss RCBs.

2.13 HCA identified several other negative effects arising from a divestiture process, including:

- (a) Divestment of the two hospitals would adversely affect HCA's business planning, putting at risk large, planned investments elsewhere [§]. Divestiture would also put at risk investment in new clinical technologies. HCA gave specific examples of new innovations that would not have been brought to HCA's network of London hospitals had HCA not owned the hospitals earmarked for divestment, such as the Sarah Cannon Research Institute and Intra-operative radiotherapy (IORT).
- (b) HCA said that the negative effects from, for example, reduced investment in nursing staff or residential medical officers or from less investment in clinical equipment could have serious implications for the quality of care received by patients, and that this would weaken the hospitals' profiles as centres of excellence.
- (c) A compulsory divestiture of assets which have taken many years to develop would also be likely to have a chilling effect on investment in the UK. Potential investors, particularly from overseas, would be justifiably concerned that long-term investment in healthcare could be at the risk of similar treatment.
- (d) The process of divestiture would have other destabilizing effects—on recruitment and retention of consultants and other clinical staff and on the readiness of overseas patients to come to London. This represented a substantial asset risk for the hospitals. HCA cited an example of how ownership uncertainty in the context of a US Federal Trade Commission investigation had caused a severe destabilizing effect on the hospital, including the large-scale defection of clinical staff.

2.14 Finally, HCA observed that under new ownership, the hospitals would not be covered by HCA's existing PMI contracts, such that new contracts would need to be negotiated and this would represent a significant risk for any purchaser of the hospitals as insurer recognition would be key to the profitability of the facilities.

- *BMI*

2.15 BMI stated that the CC's proposed divestitures would be both ineffective and disproportionate. Regarding the effectiveness of the remedies:

(a) BMI stated that divestitures would be ineffective in improving competition since its hospitals were already sufficiently constrained by competitors in their local areas.

(b) BMI questioned the extent to which lower prices charged by hospital groups would be passed through to patients. While the CC identified lower prices as an objective of the divestment remedies, BMI noted that it did not quantify or establish a framework for assessing how any benefit conferred on insurers would be passed through to customers. BMI argued that the lower prices that PMIs with market power had achieved in the past did not appear to have been passed on in lower premiums for customers. BMI said that the CC must determine whether and to what extent any remedy benefits will lower premiums charged by PMIs to final consumers.

(c) BMI stated that [REDACTED].

2.16 BMI noted that the divestitures would also be likely to weaken competition in the PMI market as Bupa's market power would be strengthened. [REDACTED], had a 40 per cent share of the PMI market and had shown—through its delisting of BMI's facilities—its readiness to use its market power against healthcare providers reliant on its volumes.

2.17 In relation to the costs and proportionality of the CC's divestiture remedies, BMI stated that:



- (a) [REDACTED]
- (b) Divestments would end BMI's current customer-benefits-focused (and pro-competitive) strategy. [REDACTED] Further, BMI explained that it would not expect any purchaser to pursue this same strategy due to the considerable investment required. The efficiencies BMI would seek were critically dependent on the implementation of this strategy and on its status as a chain of hospitals.
- (c) Efficiencies in treatment and care would be lost as these are critically dependent on BMI's status as a chain of hospitals and economies of scale/scope such that divestitures would increase the prices paid by patients as the numerous costs currently incurred centrally would need to be recouped from a smaller number of hospitals: [REDACTED].
- (d) Divestitures would most likely occur at an undervalue as BMI would face a small pool of potential buyers. [REDACTED] The paucity of potential buyers would prejudice the price obtained, particularly if the sale had to be completed within a 'pre-emptory timetable'.
- (e) Any benefits of divestitures would accrue to a small proportion of patients at BMI hospitals. BMI pointed out that the CC analysis of market outcomes focused on providers that offered inpatient care and that the CC had presented no evidence of an AEC in respect of outpatient, walk in/walk out, day-case or NHS work undertaken by those providers, despite the move in delivery of care towards these environments rather than the more traditional full inpatient care service delivery model. Moreover, because the CC acknowledged that Bupa had some countervailing buyer power (which BMI said in fact amounts to fully-countervailing buyer power) Bupa patients should be excluded from those who might benefit from enhanced PMI power.
- (f) Divestment is extremely disruptive to patients. BMI noted that healthcare delivery is a highly personal service with a complex supply chain that, if disrupted in the ways anticipated, could have long-term life and death consequences. BMI

questioned how the CC's impact assessment had regarded the risk of patient death or other serious side effects or consequences precipitated by a delay in treatment brought about through the dislocation created by forced wholesale divestitures. BMI said that for the CC to conclude that divestments were proportionate it must cost these outcomes explicitly into its cost/benefit analysis.

- (g) Where there was a choice of possible divestitures in an area, BMI should be permitted to choose which facility to divest in the absence of compelling evidence to support the divestiture of one facility over another.
- (h) The CC's analysis fails to meet the 'double proportionality' approach<sup>18</sup> suggested by the CAT where a proposed remedy is intrusive, uncertain in its effects, or wide-reaching. It said that the CC had failed by a large margin to reach the required standard of investigating the impact of divestments in a 'more detailed or deeper' manner than usual and that consequently the CC's analysis was far too weak to support divestments.
- (i) The CC has a series of measures available to it which would likely be more effective and are also less onerous to BMI and its patients. It said that these included the proposed remedies 3 to 7 which, with some modifications, BMI (notwithstanding its firm belief that there was no AEC to be remedied) would be prepared to accept. BMI stated that these remedies would likely be more effective at addressing the low barriers to entry that existed and improve the functioning of the market by empowering patients (and GPs and consultants on their behalf) to seek out the best quality service. It said that if any features of weak competitive constraints in local areas were to in fact exist, these measures would in turn allow competition and the market itself to resolve them.

---

<sup>18</sup> *Tesco v Competition Commission* (2009), CAT 6, (paragraph 139): 'it may well be sensible for the Commission to apply a 'double proportionality' approach: for example, the more important a particular factor seems to be in the overall proportionality assessment, or the more intrusive, uncertain in its effect, or wide-reaching a proposed remedy is likely to prove, the more detailed or deeper the investigation of the factor in question may need to be.'

2.18 In addition, BMI suggested that the CC's investigation was likely to adversely affect investors' (particularly foreign investors') perception of the UK as a destination for their risk capital, noting that 'the perception will be that the CC has targeted the predominantly foreign-owned private healthcare providers<sup>19</sup> and left entirely uninvestigated and uncriticized the UK-owned PMIs'.

2.19 Regarding its first point, [REDACTED].

2.20 [REDACTED]<sup>20</sup>

2.21 Finally, in respect of the time period that it should be allowed to effect the sale, BMI said that hospital sales were complex and patient interests required that significant attention be paid to transitional arrangements to ensure continuity of care and service provision. [REDACTED] In BMI's view, should the CC pursue a divestment remedy, a timetable of [REDACTED] would be appropriate.

- *Spire*

2.22 Spire argued that the CC's proposed divestiture of its locations would be both ineffective and disproportionate. Spire argued that divestitures would be ineffective since its hospitals were already sufficiently constrained by competitors in their local areas. It said that the OFT had cleared its acquisition of the Classic Hospitals in 2008, which had given rise to the network effect that the proposed remedy was intended to remove. The OFT assessment had concluded that sufficient competition would remain after the merger.

---

<sup>19</sup> BMI, Ramsay, HCA and Aspen are ultimately foreign-owned.

<sup>20</sup> [REDACTED]

- 2.23 In considering whether divestment, if confirmed, would be sufficient to address the AEC, Spire suggested that it might be necessary to introduce a ‘no poaching’ agreement to guard against a situation where the divested hospital and a retained hospital draw consultants from the same Trust. (This, it said, would not be an issue for Spire’s hospitals in Leeds, which draw their consultants from different Trusts.)
- 2.24 In relation to the proportionality of the CC’s divestiture remedies, Spire argued that:
- (a) If the divestment of any hospital were necessary, the most proportionate remedy would be the divestiture of [X]. The CC’s theory of harm could logically only relate to lower acuity treatments offered by all three of Spire’s Leeds hospitals. There was no overlap in the provision of high acuity treatments and procedures since Methley Park and Elland hospitals offered only lower acuity treatments and no ‘cluster’ issue could therefore arise in relation to higher acuity treatments. Furthermore, only the divestment of [X] could meet the CC’s LOCI-based test for divestment. If the CC were to insist on this divestment, there would be no need to divest any other facility.
  - (b) Spire noted that the CC had concluded that inpatient, day-patient, and outpatient care were distinct product markets. Accordingly, Spire argued, any remedy must be limited to inpatient care and should not touch on outpatient or day-case care.
  - (c) Any divestiture could have significant costs for the divested asset, which the CC should take into account in its assessment, including:
    - (i) The considerable efficiencies Spire had brought to the hospitals it operated could be lost in the hands of another operator, ultimately leading to higher costs for consumers.
    - (ii) The clinical excellence of its hospitals, in which Spire had invested heavily, could also be lost in the hand of another operator, resulting in a loss of competitiveness and reduced consultant confidence in the facility.

(iii) Planned investment (£[~~8~~]) may not be undertaken by another owner of the facility.

(d) Divestiture may 'chill' incentives for local entry or expansion by incumbent providers.

2.25 Should the divestiture remedy be confirmed, Spire considered that a large number of entities would have expertise, commitment and financial resources to run the divested facility competitively. These potential purchasers could be drawn from the larger, UK-based hospital operators, smaller UK-based operators, international operators, insurers, private equity firms and the NHS.

2.26 However, Spire suggested that potential purchasers might be put off by the outcome of the CC's market investigation into private healthcare, particularly its 'extraordinary approach to profitability and the risk-return available to investors'.<sup>21</sup> Moreover, it was not clear that there would be sufficient purchasers to acquire all of the divestment properties that would come on to the market at the same time.

2.27 With regard to the length of time that should be allowed for divestments, Spire commented that there might be several complicating factors:

- (a) Spire—and other hospital groups—could not easily access the full range of possible purchasers for each facility;
- (b) only a buyer without facilities in the same geographic area as a divestiture hospital would be likely to meet the CC's approval criteria for suitable purchasers; there was likely to be an insufficient number of such suitable purchasers to acquire all the divestiture assets;
- (c) Spire had limited internal resources to manage the divestiture process;

---

<sup>21</sup> Spire response to the Remedies Notice, paragraph 2.12.

- (d) in some cases, landlord or lender approval might be required for the disposal of a hospital site and might take some time to get;
- (e) it was likely that a potential purchaser would not proceed with a transaction unless the relevant PMIs confirmed that they would recognize the hospital as part of their network. Spire stated that it expected PMIs to use the opportunity of the divestments to delay and/or deny recognition, and/or renegotiate existing agreements as a condition for continuing recognition;<sup>22</sup> and
- (f) purchasers would be required to obtain additional regulatory approvals, such as CQC registration (which can take up to eight weeks).

2.28 While Spire considered that the standard six-month divestiture period the CC normally allowed should be sufficient, a flexible timeline and process might be needed.

- *Nuffield*

2.29 Nuffield said that divestiture was a crucial remedy to rebalance the market power that currently resided with HCA, BMI and Spire. Outside of central London it said that divestiture was necessary to rebalance the portfolios of hospital operators such that no single player controlled a critical mass of ‘must have’ hospitals. It said that divestiture should therefore also be considered in strategic insurer markets that the CC had classified as Single or Duopoly.<sup>23</sup>

2.30 Nuffield said that HCA might encourage consultants to transfer their practice to a retained facility and that appropriate measures should be adopted to prevent this happening.

---

<sup>22</sup> *ibid*, paragraph 2.26(e).

<sup>23</sup> Single or Duopoly areas, as set out in paragraph 24 of the Remedies Notice are areas served by one hospital (Single) or by two (or more) hospitals both/all of which are run by different operators (Duopoly).

2.31 Nuffield considered that it would be helpful for assets to be sold individually, rather than bundled for sale; this would widen the range of prospective purchasers, as well as offering more choice to the consumers and consultants. It thought that the parties should be allowed six months to effect the sale of the properties being divested.

- *Ramsay*

2.32 Ramsay believed a divestment remedy needed to be structured to ensure that all hospitals could continue to operate as viable undertakings; 'cherry-picking' should be avoided and hospitals should be sold without delay because uncertainty about its future could be detrimental to a hospital's performance and viability. Ramsay said that selling all the hospitals to be divested in one package would give a purchaser the chance to enter or expand and become a viable competitor in the private healthcare market. This would be particularly so if a package of the hospitals in central London was made available.<sup>24</sup>

- *The London Clinic*

2.33 The London Clinic (TLC) suggested that any divestments in central London should be structured as a package to ensure any new entrant could be an effective competitor. In its view, a divestment package for central London should include:

- (a) one or more hospitals currently offering a range of tertiary treatments on a sufficient, viable scale (ie London Bridge Hospital, The Wellington Hospital and The Harley Street Clinic);
- (b) oncology as a speciality within that range of tertiary treatments. The remedy should seek separate ownership of the assets and facilities which underpin HCA's dominant position in oncology;

---

<sup>24</sup> [Summary of hearing with Ramsay.](#)

- (c) a break-up of HCA's 'super-dominant' position at a sub-speciality level; in oncology, the Wellington and Leaders in Oncology Care (LOC) dominate in chemotherapy, the Harley Street Clinic and LOC hold a dominant position in radiotherapy; and
- (d) a prohibition on hospitals with significant market power in central London from making further acquisitions of hospitals or relevant assets without prior approval from the Competition and Markets Authority (CMA).

2.34 TLC considered that a suitably composed package would attract interest from several prospective purchasers, including from some not currently present in central London and from overseas buyers. In the past American organizations had been keen to enter the London market and there had been recent interest from the Far East and Middle East.<sup>25</sup> It considered that six months was a sufficiently long divestiture period.

- *Circle*

2.35 Circle strongly supported 'the principle of divestiture as the most suitable remedy to redress the entrenched dominance of the national chains and HCA'.<sup>26</sup>

2.36 In London, Circle did not consider that separate sales of single HCA hospitals would remedy the AEC or ensure the creation of a sufficiently strong new competitor. But it also did not consider that the remedy would only be effective if the entire package was divested to a single owner and thought that ownership by two or more purchasers would be most effective. Circle also proposed that:

- (a) HCA should not be permitted to run more London PPUs or acquire healthcare assets for five years; and

---

<sup>25</sup> Summary of hearing with TLC, paragraph 7.

<sup>26</sup> Summary of the hearing with Circle.



(b) consultants at divested facilities should not be allowed to move to other HCA facilities for two years.

2.37 Outside central London, Circle recommended that anti-circumvention measures be put in place to prevent consultants moving to other hospitals in a group and that PPUs operated by a divesting group should be included in the divestitures.

2.38 Both within and outside central London, Circle considered that sales should be made as soon as possible and completed within six months.

- *Insurers*

- *Bupa*

2.39 Bupa suggested that the CC's proposed divestiture remedies were insufficient<sup>27</sup> giving the following reasons:

- (a) some of the main hospital groups would be left 'broadly, if not wholly, unchanged'; the large hospital groups would still have significant scale—BMI, Spire and Nuffield in particular; small insurers would still have little buyer power;
- (b) the divestments seemed likely to create at best three competitors of similar scale and scope and this would be an asymmetric triopoly because they would have differing capacities and specialisms;
- (c) unintended consequences since, if hospital groups have the option to sell one of two facilities, they are likely to sell the smaller and weaker of the two; and
- (d) because divestments will be made in only some geographical areas, only a minority of self-pay patients will benefit from lower prices (the CC's estimate that prices will fall there by 3 to 4 per cent, while material, is not transformational).

---

<sup>27</sup> [Bupa response to Remedies Notice](#).

- 2.40 Bupa suggested, therefore, that the CC's proposed divestitures should be supplemented by other measures, such as:
- (a) price controls—for example of single hospitals, which were in effect natural monopolies;<sup>28</sup> and
  - (b) divestment of single or asymmetric duopoly hospitals.<sup>29</sup>
- 2.41 Bupa said that it should be stipulated as part of the divestment package that, ideally, the operating company and underlying property should be sold together to the new owner. It understood that several large hospital groups (eg BMI) use OpCo-PropCo structures such that a divested business may be competitively constrained if it remains locked into high rental payments to the property owner.<sup>30,31</sup>
- 2.42 In Bupa's view, some potential purchasers were not suitable, for example one of the existing large hospital groups (BMI, HCA, Nuffield, Ramsay, Spire). There was also some concern that, if these groups participated in the divestment process, they would gain sight of confidential pricing data. If an insurer purchased a divested hospital (ie if there was any vertical integration), other insurers should have access to that facility on fair and reasonable terms.<sup>32</sup>
- 2.43 Bupa also warned that a single purchaser should not itself be allowed to become so large (particularly in central London) as to be able to exert market power over insurers. Other PMIs (eg AXA PPP) said similarly that the CC should assess the overall make-up of the post-divestment holdings of individual hospital groups, both within and outside central London when it considered potential purchasers.

---

<sup>28</sup> PruHealth also supported the use of price controls.

<sup>29</sup> [Bupa response to Remedies Notice](#), paragraphs 1.28 & 4.49–4.54.

<sup>30</sup> [Bupa response to Remedies Notice](#), paragraph 4.56.

<sup>31</sup> Circle made the same argument. See [Circle response to Remedies Notice](#).

<sup>32</sup> [Bupa response to Remedies Notice](#), paragraphs 4.55–4.61.

2.44 Bupa considered that the timetable for divestment did not need to be longer than six months. If that proved unsuccessful, a divestment trustee should be appointed with a mandate to complete the deal within three months.

2.45 Bupa argued that the CC should require the divestiture of several hospitals, across a range of hospital groups:<sup>33</sup>

(a) HCA: The London Bridge Hospital and The Wellington Hospital, as well as Roodlane;

(b) BMI: Clementine Churchill, Chiltern, Kings Oak, Chelsfield Park and Sloane, Princess Margaret and Mount Alvernia, Priory, Saxon Clinic, Alexandra, Park, Fernbrae or Ross Hall, [REDACTED];

(c) Spire: Leeds, [REDACTED];

(d) [REDACTED]; and

(e) [REDACTED].

○ AXA PPP

2.46 AXA PPP Healthcare Limited (AXA PPP) considered that it was essential to have three 'credible groups' owning hospitals in London. AXA PPP would then be able to negotiate with each of these groups separately, requiring them to offer terms against each other, and AXA PPP would be able to offer patients a range of health insurance products. It set out its criteria for a credible portfolio, including ownership of a flagship hospital,<sup>34</sup> a Harley Street presence and coverage of a full range of specialisms.

2.47 AXA PPP told the CC that it did not experience the same level of disadvantage outside central London as it did with HCA. It said that while all the hospital groups had some areas where they were solus provider, this was, in most cases, broadly

---

<sup>33</sup> Bupa's views are set out in greater detail in Appendices 2.1, 2.2 and 2.3. It considered that if the CC did not impose a price control then further divestments, of asymmetric duopoly hospitals and Single hospitals, would be required.

<sup>34</sup> It said that London flagship hospitals were the London Bridge, the Wellington and TLC.

counterbalanced by them wanting to have as many of their facilities as possible recognized by insurers.<sup>35</sup>

2.48 AXA PPP suggested that where the CC had proposed the divestiture of NHS PPUs (managed by BMI), significant investment may be required to allow such facilities to compete effectively and that, even if such investment were made, these facilities would not necessarily be effective constraints.

2.49 Following a detailed review of the CC's proposed divestiture package, AXA PPP agreed with the CC's analysis and proposals for no divestitures in the North-West (Spire), East Midlands (BMI), East of England (Ramsay) and Scotland (BMI).

Furthermore, AXA PPP said that it supported the divestiture of:<sup>36</sup>

- (a) either Kings Oak or Cavell;
- (b) Shelburne;
- (c) Sloane and Chelsfield Park;
- (d) Runnymede;
- (e) Saxon Clinic; and
- (f) one of Beardwood or Highfield.

2.50 However, AXA PPP told the CC that it was ambivalent regarding the divestiture of:

- (a) either Bishops Wood or the Clementine Churchill hospital; and
- (b) Either Priory or (both) Edgbaston and Droitwich Spa.

2.51 Finally, AXA PPP told the CC that it did not support the divestiture of any of Spire's hospitals in the Leeds area.

---

<sup>35</sup> AXA PPP response to provisional findings and Remedies Notice, paragraph 2.56.

<sup>36</sup> A more detailed summary of AXA PPP's submissions in relation to these divestitures is set out in Appendix 2.2.

- *Aviva*

- 2.52 Aviva Health (Aviva) initially saw a risk that the divestiture of just certain key hospitals in central London would merely transfer market power from one owner to another. However, having reviewed the CC's divestment options paper, Aviva expressed concerns that the CC's divestment proposals did not go far enough to address the dominance of HCA in that market. Aviva highlighted that HCA owned approximately 95 per cent of all consultation rooms, outpatient and diagnostic centres in the city of London (EC1 postcode) and that it also owned additional primary care facilities and three occupational health facilities (Roodlane, Blossoms and Galen) which were all based in this area. It argued that satellite outpatient consultation rooms were effectively used by HCA as an extension of their hospital facilities and they provided a mechanism for HCA to gain control of the patient pathway at an early stage. If these outpatient and primary care facilities remained in HCA's ownership, HCA would still have control over the pathway and would be able to divert business away from any divested hospitals to its remaining facilities. Aviva, therefore, proposed that some of these outpatient, primary care and diagnostic centres would need to be included in any divestment package.
- 2.53 Outside London Aviva suggested that the proposed divestments would have a positive impact in increasing competition and driving lower prices in the local areas where the affected hospitals were located but that the national market power of hospital operators would be largely unaffected by the proposed divestments (save in a limited way in the case of BMI). In particular, Aviva noted that there were many 'hospitals of concern' in non-cluster areas which would not be affected by the CC's divestiture remedies.

2.54 Finally, Aviva told us it believed that any lower prices achieved as the result of the CC's remedies (both structural and behavioural) would be passed on to customers in lower premiums.

- *PruHealth*

2.55 PruHealth did not believe that the sale of one or more of HCA's hospitals would necessarily exert downward pressure on prices, arguing that in all likelihood the new entrant would charge the same prices as HCA.<sup>37</sup>

### *Design issues and effectiveness assessment*

2.56 We have set out in paragraphs 1.14 to 1.17 the factors that the CC takes into account in choosing appropriate remedial action, including the effectiveness of the remedy and its reasonableness and/or proportionality. As an introduction to our consideration of possible divestiture remedies, we set out some general considerations regarding divestiture, as well as specific factors that we have taken into account in this investigation.

#### *General considerations regarding divestiture remedy options*

2.57 The aim of divestiture is to address competition problems arising from structural features of a market. This may be done either by creating a new source of competition through disposal of a business or assets to a new market participant, or by strengthening an existing source of competition through disposal of a business or assets to an existing market participant that is independent of the divesting party (or parties).

2.58 Where a structural measure, such as divestiture, is appropriate, it is likely to have some advantages over behavioural measures as it will address at source the lack of

---

<sup>37</sup> [Summary of hearing with PruHealth.](#)

rivalry resulting from structural features of a market and will generally not require detailed monitoring beyond the completion of the disposal of the business or assets in question. In addition, divestiture remedies can generally be expected to address the AEC identified (and the customer detriment arising) in a timely manner.

2.59 We considered whether there were any other, potentially less intrusive, remedies that would be as effective as divestiture. As we explain in more detail in Section 3, we do not believe that there are any behavioural remedies that will be effective in addressing the AEC by constraining the market power of the private hospital operators in local areas or in their negotiations with the insurers. Similarly, we have considered but rejected the remedy of a price control (see Section 3), which we thought would only be partially effective in addressing the AECs arising from weak competitive constraints in local areas.<sup>38</sup> In addition, we thought a price control would create potentially damaging distortions to the market, particularly with regard to quality and innovation, as well as being very costly to implement, monitor and enforce.<sup>39</sup> Finally, we considered whether our information remedies would address the weak competitive constraints in many local areas. We reasoned that, in the longer run, they were likely to increase the constraints on hospitals and consultants by enabling both patients and insurers to make meaningful choices between providers on the basis of their value proposition (ie their price-quality offering). In particular, we thought that the greater availability of quality information might encourage patients to travel further where they perceived a quality benefit from doing so, effectively increasing the size of local markets and therefore the number of hospitals contesting those markets. However, we did not think that this customer response would be sufficiently strong within the foreseeable future to address substantially the AECs identified in local markets. We concluded, therefore, that

---

<sup>38</sup> We thought that while a price control may be effective in reducing prices, it would be unlikely to encourage competition on quality or innovation in the market.

<sup>39</sup> See Section 3 for our detailed consideration of a price control remedy.

divestiture remedies were the only effective and reasonable solution to the AECs identified in cluster locations.

2.60 To be effective, a divestiture should involve the disposal of an appropriate divestiture package to a suitable purchaser through an effective divestiture process. An effective divestiture remedy is therefore based on three critical elements:

(a) *Appropriate divestiture package.* In general, a divestiture remedy is more likely to be effective if the divestiture package comprises a unit that is able to compete effectively on a stand-alone basis rather than a collection of assets. The CC will normally seek to identify the smallest operating unit whose divestiture will address the AEC.

(b) *Suitable purchasers.* Suitable purchasers should be independent of the divesting party or parties and any related party, and should have appropriate expertise, commitment and financial resources to operate and develop the divested business as an effective competitor. In addition, acquisition of a divestiture package by a suitable purchaser should not itself create further competition or regulatory concerns.

(c) *Effective divestiture process.* An effective divestiture process should ensure that divestiture of an appropriate divestiture package to a suitable purchaser takes place within a reasonable time period. It should also ensure that the business to be divested does not deteriorate prior to its sale.

- *Effectiveness and local market characteristics*

2.61 We provisionally concluded that it is a feature of this market that there are weak competitive constraints in many local markets. Such weak competitive constraints may arise in two different situations.



- 2.62 First, there may be several hospitals in a local area that are wholly or predominantly operated by one operator. In these circumstances there will be little or no rivalry between the hospitals concerned. We use the term ‘Cluster’ where a private hospital operates two or more facilities in the same local area, such that the facilities have overlapping catchment areas. Alternatively, a local area may be served by one hospital only or by two hospitals managed by different operators. We refer to these as ‘Single’ and ‘Duopoly’ areas respectively.
- 2.63 We reasoned that divestiture in Single or Duopoly areas would not be an effective remedy since, in both cases divestiture would substitute one rival for another rather than introduce more rivalry. A divestiture remedy would, therefore, only be effective in those areas where we have competition concerns in which Clusters of hospitals are owned by the same operator.
- 2.64 As set out in our provisional findings<sup>40</sup> we defined a separate central London market as the geographic area enclosed by the north and south circular roads. Within this area, we observed that market conditions both on the demand side and on the supply side, differ markedly from those prevailing elsewhere in the UK or are more evident in central London than elsewhere.<sup>41</sup> Within this local market, we noted that HCA owns and/or operates a number of private healthcare facilities. On this basis, we considered that divestments could address the AEC in central London since here a cluster of hospitals is owned by a single operator, HCA. Our approach and reasoning concerning an appropriate divestiture package for central London is set out in Appendix 2.1.

---

<sup>40</sup> See [provisional findings report](#), paragraph 5.59.

<sup>41</sup> In particular, central London is characterized by a high PMI penetration rate, in part arising from the large presence of corporate PMI customers; a significant number of patients travelling from greater London and outer London into central London; a significant number of private hospitals and PPUs, with a widespread offer of complex treatments or specialties; strong reputation of some private hospitals and PPUs which are perceived by patients as offering a higher quality of care than private hospitals and PPUs elsewhere in the UK; and private hospitals and PPUs in general drawing patients from very wide geographic areas.

2.65 In local areas outside central London, we reasoned that the divestiture of one or more hospitals would increase competitive constraints where the catchment areas of two or more co-owned hospitals overlapped. We noted that our measure of LOCI ‘network effect’ identified areas where this was the case and could be used, therefore, as a filter to find local areas in which operators owned or managed ‘clusters’ of hospitals. While a network effect greater than zero indicates that divestiture would increase competitive constraints, we reasoned that a change in the network effect of approximately 20 percentage points could be used as a proxy for a ‘significant’ level of overlap between the catchment areas of hospitals and therefore a substantial change in the level of competitive constraints in an area. We reached this view on the basis of our price concentration analysis, which indicated that a 20 percentage point decline in the weighted average market share would result in a decline in prices of between 3 and 4 per cent, which we judged to be significant. Our full methodology and reasoning is set out in Appendix 2.4.

2.66 Applying this approach, we identified a list of hospitals located in ‘cluster’ areas. In each case, we then considered which other co-owned facilities had overlapping catchment areas and should be considered as part of the same ‘cluster’. We invited comments on our analysis from affected parties and the larger insurers<sup>42</sup> at the time we published our Remedies Notice.

2.67 We note that a number of the private hospital operators, including BMI and Spire, questioned the robustness of our approach to identifying ‘clusters’ of hospitals.<sup>43</sup> While, as explained in paragraph 2.8, we will not address parties’ submissions on the

---

<sup>42</sup> Bupa, AXA PPP and Aviva.

<sup>43</sup> Spire questioned the CC’s reliance on the identification of clusters, stating that there had been no articulation of how or why clusters give rise to competition problems.

provisional findings in this document,<sup>44</sup> we note that we have used the LOCI network effect only as a filter to identify areas in which co-owned hospitals have overlapping catchment areas. For each hospital of concern with a LOCI network effect in excess of 0.2, we have conducted a detailed analysis of the competitive dynamics in the local area in order to come to a view on the extent to which a divestiture may be an effective and proportionate remedy to the weak competitive constraints in that area. In several cases, we have determined that divestitures would not be effective or proportionate despite a hospital having a LOCI network effect in excess of 0.2. Our proposed divestitures, as set out in this provisional decision on remedies are not, therefore, dependent on the LOCI measure or our identification of a number of co-owned hospitals as forming a ‘cluster’ but rather on an area-by-area assessment.<sup>45</sup>

2.68 We considered the extent to which our proposed divestitures would affect prices. We noted that the results of our price concentration analysis—which estimated that self-pay prices decline by between 3 and 4 per cent for every 20 percentage point reduction in weighted average local market share—show that divestitures which reduce local market shares should have a direct effect on the prices charged to self-pay patients. We were unable to conduct a price concentration type analysis for patients covered by insurance as prices are generally set by private hospital operators nationally rather than on a hospital by hospital basis. However, we analysed the prices charged by the private hospital operators to insurers (‘Insured Price Analysis’) and found that insurers tended to pay higher prices to hospital operators where the latter have more hospitals facing weak competitive constraints in locations that are important to the insurer (and its customers).<sup>46</sup> AXA PPP highlighted the importance of this relationship between local and national market power in its response to the

---

<sup>44</sup> These are currently being reviewed and our consideration of them and final conclusions will be set out in our final report. In many cases, the main contention of the parties is that LOCI is not a good measure of market share.

<sup>45</sup> See Appendix 2.4.

<sup>46</sup> See [provisional findings report](#), paragraphs 6.240–6.242.

Remedies Notice.<sup>47</sup> We concluded that this supported the finding that weak constraints in local markets result in higher prices being negotiated with insurers. On this basis we reasoned that the divestiture of one or more hospitals in areas where a hospital operator faces weak competitive constraints would also serve to reduce insured prices at the national level. We have set out our detailed analysis of the likely impact of divestiture on the prices charged to both self-pay and insured patients in Appendix 2.5. Our detailed analysis of the effectiveness of a divestiture remedy in a given local area is set out in Appendices 2.1 and 2.2.

- *Use of divestitures to address national market power*

2.69 Several parties, including Bupa and Nuffield, put forward the view that the CC should specify divestiture remedies in non-cluster areas in order to reduce the scale of some of the larger private hospital operators. This approach to remedies is not consistent with our provisional findings that the level of national prices is the result of the level of market power held by the private hospital operators in each of the local areas in which they operate rather than due to the overall scale of the private hospital group.<sup>48</sup> As explained in paragraph 2.8, we have based this document on the AEC as set out in our provisional findings and have not, therefore, taken these arguments regarding national scale into account here. They will, however, be considered in reaching our conclusions on the existence and nature of the AEC for the final report. The divestiture remedies that we propose in this document seek to address the AEC that we provisionally found to result from weak competitive constraints in a number of local areas throughout the UK (both in central London and elsewhere).

---

<sup>47</sup> 'AXA PPP highlights the proportion of 'must have' facilities since the main form of countervailing bargaining power available to insurers faced with a hospital group with a number of must-have facilities involves bargaining over inclusion, or the terms of inclusion, in more competitive areas.' [AXA PPP response to Remedies Notice](#), paragraph 2.56.

<sup>48</sup> In effect, we found that the national prices paid by insurers were equivalent to the weighted average of the local prices that they would have paid for each hospital if all prices were negotiated separately. We did not find a compelling theory, or evidence to suggest that local market power could be magnified via common ownership.

- *Pass-through of price benefits*

2.70 Several of the private hospital groups questioned whether any price reductions that resulted from divestitures would be passed through to the ultimate consumers, ie policyholders. For example, BMI stated that despite the fact that smaller insurers currently pay significantly more than Bupa and AXA PPP, they were able to compete with these firms on price. BMI said this strongly suggested that AXA PPP and Bupa were not currently passing on the full benefit of their lower prices. HCA said that there were good grounds for believing that the supply of PMI was not competitive. Supply is highly concentrated (the four major PMI providers, Bupa, AXA PPP, Aviva and PruHealth, accounted for 87 per cent of the market in 2012) and concentration has been stable over time (ranging from only 87 per cent to 87.5 per cent during 2008 to 2012).<sup>16</sup> HCA submitted that the PMIs' resistance to quality improvements and innovation was consistent with an uncompetitive PMI market, where PMIs saw little incentive to improve the quality of their offering to policyholders in order to attract new patients.<sup>17</sup> Furthermore, HCA considered that its view of the lack of competition in the supply of PMI was supported by the existence of captive PMI policyholders who were unable to switch in response to changes in the value of a PMI's offering.

2.71 We disagreed with the argument put forward by the private hospital operators on three grounds. First, we note that our responsibility in designing and implementing remedies as part of a market investigation is to, in relation to each adverse effect on competition, take such action under section 159 or 161 of the Act as we consider to be reasonable and practicable:

(a) to remedy, mitigate or prevent the adverse effect on competition concerned; and

---

<sup>16</sup> Supplemental submission following HCA's remedies hearing, December 2013, paragraph 1.19.

<sup>17</sup> Supplemental submission following HCA's remedies hearing, December 2013.

(b) to remedy, mitigate or prevent any detrimental effects on customers<sup>49</sup> so far as they have resulted from, or may be expected to result from, the adverse effect on competition.<sup>50</sup>

2.72 We have provisionally found an AEC arising from a lack of local competitive constraints in the market for private healthcare services. We estimated that this gave rise to detriment of between £173 million and £193 million a year.<sup>51</sup> This detriment takes the form of higher prices charged to customers in the private healthcare market, including self-pay patients, insurers and insured patients. We consider that it is appropriate for our remedies to seek to address the AEC and the consequent detrimental effects on these customers.<sup>52</sup>

2.73 The divestiture remedies, set out in this section of the provisional determination on remedies, as well as the other remedies we propose implementing, would have the effect of increasing the competitive constraints acting on the private hospital operators, exerting downward pressure on prices and encouraging competition on quality and innovation. These price benefits would be enjoyed directly by the customers, ie self-pay patients, insurers and insured patients (to the extent that they make co-payments). Similarly, any quality or innovation benefits would accrue directly to the patients treated at these facilities, whether self-pay, insured or NHS.

2.74 Second, we note that BMI's and HCA's argument relates to the extent to which the (price) benefits of our remedies would be passed to the ultimate consumers of the healthcare services, ie to private healthcare patients. They contend that the insurers might not pass any/all of the benefits of any reduction in the costs of private hospital

---

<sup>49</sup> CC emphasis added.

<sup>50</sup> Section 138, the Act.

<sup>51</sup> [Provisional findings](#), paragraph 10.8.

<sup>52</sup> We include insured patients in this context since they are often liable for some portion of the costs of their treatment via excesses on their policies, as well as, in some cases, co-payments. As a result, they directly fund part of their treatment even when covered by insurance.

treatment to their policyholders. However, we disagreed with this view since we observe that the benefits arising from our remedies will be passed in full to both self-pay patients and to employees whose health cover is provided by corporate trusts. We note that self-pay patients account for approximately 15 per cent of independent acute hospital revenues in 2012 (and around 20 per cent of the private revenues of those hospitals), while corporate trusts accounted for around 15 per cent of the total claims expenses of the insured market, or around 11.5 per cent of the total private revenues of the hospital operators.<sup>53</sup>

- 2.75 Third, we note that in the case of insured patients, economic theory indicates that even a monopolist would pass through a proportion of the reduction in cost, with a competitive market resulting in substantially all the benefit being passed to patients. We thought that the insured market could be divided into large corporate customers on the one hand and SMEs and individuals on the other. We noted that AXA PPP's argument that the private medical insurance market for large corporate customers is highly transparent, with pricing based on the costs incurred by insurers in the previous period, tended to indicate that a significant proportion of the cost reduction would be likely to be passed through in this segment. The large corporate segment accounts for 22 per cent of the total PMI market and is likely to comprise a larger proportion of claims costs (and hence revenues to private hospital operators) due to the higher loss ratios on this business.<sup>54</sup> Even assuming that it accounts for only 22 per cent of insured spend with private hospital operators, this comprises 17 per

---

<sup>53</sup> Self-pay patients comprise 14.5 per cent of independent acute hospital revenue in 2012 (or £629 million), according to Laing & Buisson (Private Acute Medical Care 2013 UK Market Report, p13). Self-pay patients accounted for 20 per cent of total *private* revenues (ie stripping out NHS revenues, which comprised 27.5 per cent of total revenues in 2012).

In the case of corporate trusts, the prices paid by the trusts on behalf of claimants are those agreed between the PMIs and the private hospital groups. Corporate Trusts account for approximately 15 per cent of the claims paid by the insured sector (L&B Health Cover, UK Market Report, 2013, p30). On the basis that insured patients comprise 55.1 per cent of the total income of private hospital operators (L&B, Private Acute Medical Care 2013 UK Market Report, p13), this equates to approximately 8 per cent of the total revenues of the private hospital operators, or around 11.5 per cent of their private (non-NHS) revenues.

<sup>54</sup> According to Laing & Buisson (Health Cover, UK Market Report 2013, p23), large corporate customers spend approximately £957 million on private medical cover, out of a total of £4,420 million (including individual policies and corporate trust spending). This equates to approximately 22 per cent of the insured market. We note that as loss ratios tend to be higher for large corporate customers, we expect them to account for a higher proportion of claims costs, ie spending on private healthcare services.

cent of the total private revenues generated by these businesses.<sup>55</sup> Therefore, we consider that it is highly likely that a significant proportion of the price benefits of our divestiture remedies will be passed through to policyholders comprising approximately half the total market.

2.76 Finally, as noted above, for SME businesses and individual policyholders, economic theory indicates that at least a proportion of the price benefits resulting from any divestiture remedies would be passed through to policyholders, even if the PMI market were not fully competitive.

- *Appropriate divestiture package*

2.77 We considered that an individual hospital was the smallest unit that could be expected to operate effectively on a stand-alone basis. Therefore, we thought that the appropriate divestiture package to specify in most cases was the relevant hospital operating business owned by the divesting party, ie the trade and assets of the hospital. Where the hospital property was also owned by the divesting hospital operator, we thought that this should form part of the divestiture package.<sup>56</sup>

2.78 In general, where a hospital building was leased from a third party, we thought that it would be appropriate to require the lease to be assigned to any purchaser of the business. In some cases, however, we considered that it might be difficult to sell the hospital business with its existing lease in place [✂].<sup>57</sup> In these cases, we have specified an alternative divestiture package that comprises the hospital operating business and the hospital property, which is owned by a related party. We note that we would only require this alternative divestiture package to be sold, ie including the

---

<sup>55</sup> PMI customers accounted for 55.1 per cent of private hospital operators' income in 2012 and 76 per cent of their total private income (stripping out the 27.5 per cent of income generated by treating NHS patients). Laing & Buisson (Private Acute Medical Care 2013 UK Market Report, p13).

<sup>56</sup> For the avoidance of doubt, the terms "hospitals", "businesses" and "assets" when used in discussion of the divestiture package all refer to the trade and assets of the divested hospitals as set out here.

<sup>57</sup> These all relate to BMI divestitures.



freehold properties, if an attempt to divest the hospital operating businesses with their current lease arrangements in place were likely to be unsuccessful or if it were likely that a purchaser would be unable to compete effectively following its acquisition of the hospital with those lease arrangements in place.<sup>58</sup>

2.79 Our consideration of the appropriate divestiture package is set out in detail in Appendices 2.1 and 2.2.

- *Availability of suitable purchasers*

2.80 HCA, BMI and Spire suggested that by requiring private hospital operators to divest assets that they had legitimately acquired or developed, the CC might deter investors from making further investments in the UK market, including acquiring any divested hospitals. Spire further argued that the scale of the CC's divestitures might mean that there were not sufficient purchasers for all the assets sold. We do not consider these concerns to be well-founded given the level of interest in the UK private healthcare market from both existing operators and overseas businesses. In particular, we note the high level of interest in the central London market. For example, [X], whilst both [X] and [X] expressed an interest in acquiring hospitals in central London. Spire told us that there was likely to be interest in acquiring hospital assets from a large number of potential purchasers, including the larger, UK-based hospital operators, smaller UK-based operators, international operators, insurers, private equity firms and the NHS. [X].<sup>59</sup> In addition, the [X] has approached the CC since the publication of our provisional findings, expressing an interest in purchasing hospital assets. Nueterra has also expressed an interest in entering the UK market.<sup>60</sup>

---

<sup>58</sup> For example, this may be the case where the owner did not generate sufficient profit after paying the rent charge on the facility to invest in developing new services.

<sup>59</sup> [Ramsay hearing summary](#).

<sup>60</sup> [Nueterra response to provisional findings and remedies notice](#).

- 2.81 [REDACTED], Bupa expressed concern that any purchaser of BMI's hospitals might not be able to compete effectively if it remained 'locked into high rental payments to the property company (landlord) owning the underlying property'. Bupa suggested that the appropriate divestiture package would, therefore, comprise both the operating company and the underlying property.
- 2.82 [REDACTED]
- 2.83 We do not agree [REDACTED].<sup>61</sup>
- 2.84 We consider that a low rent cover could deter an investor from acquiring a hospital, since this may make the net profitability of a facility sensitive to relatively small changes in revenues. Equally, we share BUPA's concern that a low level of net profit could prevent a purchaser from investing in a facility and thereby competing vigorously with the incumbent operator. [REDACTED] We have considered the potential impact of BMI's current lease arrangements on a case-by-case basis. As set out in paragraph 2.78, in some instances, we agree that an alternative divestiture package needs to be specified, whilst in others, we consider that the sale of the operating business of the hospital would create an effective competitor. Our specific considerations in this respect are set out for each local area in Appendix 2.2.
- 2.85 In order to ensure the success of divestiture remedies, the CC will require that prospective purchasers meet our suitability criteria, which are consistent with our market guidance.<sup>62</sup> In summary, we will wish to satisfy ourselves that all prospective purchasers:

---

<sup>61</sup> [REDACTED]

<sup>62</sup> CC3, Annex B, Remedial Action, [paragraphs 17 to 22](#).

- (a) are independent of the divesting parties, such that the purchaser is able to compete vigorously;
- (b) have appropriate financial resources, expertise and assets to enable the divested business to be an effective competitor in the market. Appropriate financial resources include a capital structure of the purchaser that permits adequate resources to continue to develop the acquired hospitals as competitive entities. Appropriate expertise would include expertise and experience in operating hospitals of a level of acuity and specialism appropriate to the hospitals being divested. In the case of London, we would consider carefully the expertise of the purchaser in operating high acuity facilities in particular;
- (c) has an appropriate business plan and objectives for competing in the UK private healthcare market; and
- (d) does not raise further competitive or regulatory concerns. In this case, we note that existing UK hospital operators with facilities in close proximity to the divestiture facilities are unlikely to be considered to be suitable purchasers. Furthermore, where the CC specifies the divestiture of two or more hospitals in a local area, our preference will be for the facilities to be sold to different purchasers unless there is a compelling competition reason for permitting a single purchaser to acquire both/all the facilities.

- *Effective divestiture process and divestiture period*

- 2.86 We will require that an effective divestiture process takes place which protects the competitive potential of the divestiture package before disposal and enables a suitable purchaser to be secured in an acceptable timeframe whilst enabling the vendor(s) to achieve an appropriate market value from the sale.
- 2.87 The main concern that respondents raised in this respect was the potential for the divesting firm to encourage consultants practising at the divestiture hospital(s) to

move their practice to other hospitals within the same group. This would both divert revenue back towards the divesting hospital group and potentially undermine the viability of the hospital being divested. A second concern was that a lengthy divestiture process may disrupt the operations of the divestiture hospitals and create uncertainty for staff, potentially encouraging them to leave and thereby damaging the performance of the business. Certain hospital operators expressed concerns that insurer recognition would cease on sale and this would impose a major uncertainty on purchaser interest. Finally, several parties expressed views as to whether the hospitals to be divested should be sold individually, or should be 'bundled' together.

2.88 We considered these submissions in the light of our guidelines on divestiture remedies and the risks that may arise when the CC implements a divestiture remedy. These comprise composition, purchaser and asset risks.<sup>63</sup> Our guidelines state that divestiture risks can be overcome, at least in part, through the design of the divestiture and by adopting protective measures such as the appointment of monitoring and divestiture trustees and alternative divestment packages.<sup>64</sup>

2.89 We considered that it would be appropriate to adopt the following measures to ensure an effective divestiture process:

- (a) agree undertakings with or implement an order on the divesting party(ies) which impose a duty to maintain the business being divested in good order and not to undermine its competitive position. In particular, we would require a commitment from the divesting hospital group not to encourage or induce consultants or key

---

<sup>63</sup> CC3, p92.

<sup>64</sup> An alternative divestment package may comprise a more extensive package which is considered may be easier to market in the event that a buyer cannot be found for the original package.

nursing or technical staff to move their practise (or employment) to the group's retained facilities;<sup>65</sup>

- (b) appointment of a monitoring trustee to oversee compliance with the undertakings;
- (c) require the insurers to roll over their existing contract terms with the divested hospitals for a period of 18 months from the date of divestiture, whilst permitting a shorter period by mutual agreement. In choosing this 18-month period, we sought to balance the need to prevent disruption to patients and to enable the vendors to receive an appropriate market value from the sale by obviating the risk of losing insurer recognition, against the desire to ensure that competitive constraints were increased as soon as possible to remedy the AEC;
- (d) require the hospital divestiture process to take place individually and simultaneously, such that purchasers can seek to acquire whichever combination of assets they consider best meets their strategic objectives (subject to the caveat that no further competition issues are created). We reasoned that such a process would maximize the interest in the assets being divested, ensuring that an appropriate market price could be achieved by the divesting firms;
- (e) specify a sufficient but not excessive timeframe for an orderly divestiture process to enable a suitable purchaser to be secured in an acceptable timeframe whilst enabling the vendor(s) to achieve an appropriate market value from the sale. We discuss what an appropriate divestiture period might be below; and
- (f) if a divesting party has not entered into a binding agreement to sell the divestiture package to a suitable purchaser by the end of the specified divestiture period, the CC will have power to appoint an independent divestiture trustee to dispose of the package(s) within a further specified period to a suitable purchaser for the best terms available in the market circumstances but without a reserve price.

---

<sup>65</sup> In this respect, we note that our Remedy 4 regarding consultant incentives should act to reinforce these undertakings by preventing hospitals from making direct payments either in cash or in kind to consultants.

2.90 The large majority of respondents to the Remedies Notice, including Spire, Nuffield and TLC suggested that a six-month timeframe would be sufficient for the divestiture of hospital facilities. We considered BMI's suggestion that an [X] time frame would be required due to the complexity of managing multiple sales processes, the need to put in place transitional arrangements to ensure continuity of care and the time that buyers will require to undertake detailed due diligence. However, we noted that these same issues would need to have been addressed by Nuffield when it sold nine of its hospitals to BMI in 2008 and that this divestiture was completed within approximately six months. Moreover, we took into account the fact that a number of potential purchasers have already expressed an interest in acquiring UK hospital assets, which suggests that a lengthy marketing phase would not be required.

2.91 On this basis we considered that a time frame for the initial divestiture period of [X] months would be feasible. However, to ensure that the vendors have sufficient opportunity to achieve appropriate market value given conditions of multiple hospital sales we consider that a divestiture period of [X] months is appropriate from the date of acceptance of undertakings or the making of a divestiture order. We consider that this period would also ensure that the AEC we have identified was addressed in a timely manner.

- *Previous OFT decisions*

2.92 We have considered the arguments put forward by some parties in relation to previous clearance merger decisions. HCA for example referred to an acquisition it had made in 2000 under the Fair Trading Act 1973 and BMI to an acquisition in 2008. We also note that when in 2001 HCA sought to acquire significant interests in the London Heart Hospital, the OFT referred the matter to the CC and HCA then abandoned the proposed transaction.

2.93 We noted that markets evolve and change over time as does the nature of the analytical tools used by the competition authorities. Given this, there may be a number of reasons why a different analytical approach may be taken by the relevant authorities at different times and under different legislative frameworks. In addition, in a market investigation far greater data may be available as well as sufficient time to undertake more detailed analysis. In the present investigation we have examined in detail the characteristics of the hospital operators, the characteristics of each hospital's location and patients, the prices charged and the profits generated. In addition, the Act gives the CC power to include the structural remedy of divestment and this is not circumscribed by previous regulatory interventions in the way submitted in particular by HCA. Moreover, just as the OFT and the CC are not precluded from adopting different analytical techniques in different cases and departing from their previous decisions when appropriate, we considered that our proposed divestment remedy did not introduce a form of 'double jeopardy' or give rise to a 'breach of legitimate expectations', nor was our market investigation or the appropriateness of particular remedies restricted by decisions taken several years earlier under a different regime.

### *The proposed divestitures*

2.94 In this section, we discuss the factors that we have taken into account in considering the effectiveness of divestitures in each local area of the UK where we identified clusters of facilities. We reasoned that five main factors could be relevant to the effectiveness of the divestiture package:<sup>66</sup>

- (a) the range of medical services (specialties) offered by the hospitals, including the availability and type of ICU;

---

<sup>66</sup> We consulted on the appropriateness of these factors in the Remedies Notice. We did not receive any responses from parties suggesting that these factors did not form an appropriate basis on which to conduct our analysis.

- (b) the location of the hospital of concern and distance from both other hospitals owned by the same operator and competing facilities;
- (c) the catchment areas of the hospitals in areas of concern and the extent to which co-owned hospitals have overlapping catchment areas;
- (d) the mix of patients treated at the hospitals, ie insured, self-pay, overseas and NHS; and
- (e) the size of the hospitals in terms of admissions and their level of spare capacity.

2.95 We reviewed in detail the parties' submissions on the specific divestitures proposed by the CC. In addition, we took into account their responses on our provisional finding of insufficient competitive constraints in the areas where we were considering divestitures. As a result of this review, we note that we have changed our view on the extent to which the following hospitals are sufficiently constrained by the competition:

- (a) BMI Runnymede, Mount Alvernia and Edgbaston—these hospitals were previously considered to be insufficiently constrained but we have revised our view and now believe that they are sufficiently constrained; and
- (b) Spire Leeds—this hospital was previously considered to be insufficiently constrained but we have revised our view and now believe that it is sufficiently constrained.

2.96 These changes have been taken into account in each area-by-area assessment of the effectiveness of divestitures. These detailed assessments for each area of the UK, both in central London and in other local areas outside central London, are set out in Appendices 2.1 and 2.2 respectively.

2.97 In the next section, we set out which hospital(s) we consider should be divested in order to remedy the AEC in each local area, highlighting areas where our proposals have changed since we provided the Divestment Options paper to parties following



publication of our Remedies Notice.<sup>67</sup> We then set out our consideration of the costs and benefits of our proposed divestitures before concluding on the overall proportionality.

### *Divestiture locations*

2.98 In Appendices 2.1 and 2.2, we set out our detailed assessment of the likely effectiveness of remedies in each of the local areas identified in Table 1. Table 2 summarizes our conclusions in this respect. We note that we no longer believe that divestitures are likely to be appropriate in the following areas:

- (a) Guildford–Runnymede–Windsor;
- (b) Birmingham–Droitwich Spa; and
- (c) Leeds.

2.99 In addition, we have revised our conclusions in the following areas:

- (a) BMI Manchester to Gisburn—we now consider that only a single divestiture is required and propose that this should be the Highfield hospital;
- (b) BMI south-east London—we now consider that the divestiture of either Sloane or Shirley Oaks would be equally effective, when combined with the divestiture of Chelsfield Park, and therefore have not specified which of these hospitals should be divested.

---

<sup>67</sup> The Divestment Options paper was provided to BMI, HCA, Spire, AXA PPP, BUPA and Aviva for their comment.

TABLE 2 **Areas in which divestitures have been considered**

<i>Local area</i>	<i>Hospital operator</i>	<i>Hospitals in the cluster</i>	<i>Proposed divestitures</i>
Central London	HCA	Wellington, Princess Grace, London Bridge, Harley Street Clinic, Lister, Portland, NHS UCLH, LOC	London Bridge and Princess Grace
Greater London (north-west)	BMI	Bishops Wood and Clementine Churchill	Bishops Wood (or Clementine Churchill)
Greater London (north-west)	BMI	Chiltern and Shelburne	Shelburne (or Chiltern)
Greater London (north)	BMI	Cavell and Kings Oak	Cavell (or Kings Oak)
Greater London (south-east)	BMI	Blackheath, Sloane, Shirley Oaks, Chelsfield Park and Fawkham Manor	Chelsfield Park and either Sloane or Shirley Oaks
Midlands (Birmingham)	BMI	Priory, Edgbaston, Droitwich Spa, Meriden	None
Midlands (Milton Keynes/ Northampton)	BMI	Three Shires, Saxon Clinic, Manor	Saxon Clinic or Three Shires
North-West (Manchester)	BMI	Gisburne Park, Beardwood, Beaumont, Highfield and Alexandra	Highfield
Yorkshire	Spire	Leeds, Methley Park and Elland	None
Lincoln	BMI	Lincoln and Park	None
Scotland	BMI	Carrick Glen, Ross Hall and King's Park	None

Source: CC.

### *Consideration of costs and benefits of divestitures*

2.100 Having identified the areas in which divestiture is likely to be an effective remedy, in this section we consider in detail the costs and benefits that are likely to result from our proposed package of divestitures, as set out in Table 2.

- *Costs of divestiture*

2.101 As set out in paragraphs 2.10 to 2.55, BMI, HCA and Spire highlighted a number of potential costs associated with the CC's (initial) proposed divestiture package. These included [REDACTED], a lowering of quality of private healthcare services, the loss of economies of scale, divestiture of facilities at below their fair market value, and the transaction costs associated with the sale of the hospitals. In this section, we consider each of these arguments in turn, setting out the conclusions that we have reached. At the end of this section, we also set out our estimate of those costs of divestiture that can be quantified.

[REDACTED]

2.102 [REDACTED]

2.103 [REDACTED]

2.104 [REDACTED]

2.105 [REDACTED]<sup>68</sup>

2.106 [REDACTED]<sup>69</sup>

2.107 [REDACTED]<sup>70</sup>

2.108 [REDACTED]

#### *Loss of quality in healthcare provision*

2.109 Both BMI and HCA put forward the argument that an alternative operator of their (respective) divested facilities may choose to follow a different strategy to theirs, [REDACTED]. We acknowledge that, were some of HCA's and BMI's hospitals to be acquired by another operator, it is possible that the purchasers and/or divesting firms might seek to reposition themselves both vertically, in terms of quality, and horizontally, in terms of the types and range of services they offer were they to judge that this would be more profitable. However, we believe that suitable purchasers for these hospital assets are likely to have both the ability and incentives to pursue a strategy that does not disadvantage private patients in terms of either the quality or the range of medical services provided.

---

<sup>68</sup> [REDACTED]

<sup>69</sup> Full details of our approach to estimating the impact of divestiture on the profitability of the hospitals are set out in Appendix 2.5.

<sup>70</sup> [REDACTED]

2.110 In central London HCA and its competitors have generally sought to pursue a high-acuity, high-quality strategy because of the commercial attractiveness of these lines of business and it seems likely to us that any acquirer would have the incentives to do the same. An acquirer would be equally aware of the high growth rate and profitability of more complex specialisms and would be likely to continue to invest in them. Equally, however, the new owner or owners might adopt a different strategy if this is what signals from the newly competitive London market suggested was optimal. We thought that in either circumstance the new competitive dynamics in London would ensure that patients' needs would be adequately met.

2.111 [X] We consider, therefore, that any purchasers of BMI's hospitals would be likely to follow a similar strategy to that set out by BMI. However, as discussed in the central London context, new owners might adopt a different strategy if this is what signals from the more competitive local markets suggested was optimal. We thought that in either circumstance the increase in competition would ensure that patients' needs would be met at least as well as they currently are and would, most probably be met to a greater extent.

2.112 In addition, we note that [X] another owner may have a greater ability to invest in the hospitals than BMI does, with the result that even more investment/innovation may be expected. Both within and outside central London, we note that in a more competitive market, with greater availability of quality information,<sup>71</sup> we would expect firms to have even greater incentives to maintain quality standards.

2.113 HCA put forward the argument that it provided not just high complexity, high acuity healthcare services but that it also delivered high quality healthcare, greater innova-

---

<sup>71</sup> Our proposed remedies to increase the availability of hospital and consultant quality information are set out in detail in paragraphs 2.405 to 2.534.

tion and a greater choice of products or services than other operators. It said that these RCBs would be lost to the detriment of patients if it were required to divest any of its hospitals. HCA suggested both that it would be unable to continue to offer the same quality of care following a divestiture and that a purchaser of its Princess Grace and London Bridge hospitals would be unable to do so. These arguments are considered in detail in Appendix 2.1.

2.114 As regards the quality of care provided by HCA, we concluded that the evidence we had seen indicated that HCA did provide good quality healthcare services, certainly in the three areas on which it submitted case studies,<sup>72</sup> but that we did not have sufficient evidence to conclude that its service quality was higher than its close competitors in central London, for example TLC and King Edward VII. We noted that lack of comparative quality or performance data was a feature of this market.

2.115 In terms of innovation, whilst we thought that a large proportion of the innovations cited by HCA were concentrated in cancer care and that some examples of innovation, for example its adoption of commercially available software such as Mosaik, were difficult to characterize as innovation, we did accept that HCA had demonstrated that it had been willing and able to adopt innovative techniques. However, in several cases innovative techniques or technologies had been adopted in response to competitors' behaviour. We thought that this stimulus to innovation would increase as a result of our divestiture remedy.

2.116 Finally, we considered that HCA's evidence on choice of treatments showed that it had to a certain extent widened the range of, in particular, high acuity treatments

---

<sup>72</sup> These were breast cancer treatment, cardiac care and orthopaedic care.

available outside of the NHS. We noted that other hospitals in central London however, for example TLC, had adopted a similar strategy.

2.117 However, we thought that HCA had failed to provide evidence that, were another suitable purchaser to take over the Princess Grace and London Bridge hospitals, the new owner would offer lower standards of services than HCA or that it would switch its emphasis to lower acuity work. We thought that a new owner or owners, like existing operators in central London, would be likely to adopt a similar strategy to HCA's. Further, the CC must approve any purchaser of the hospitals concerned and as part of the approvals process will examine the business plans of prospective purchasers. On this basis we thought we could be reasonably sure that the new owner would have the ability to pursue such a strategy.

2.118 Nor did we conclude that our proposed divestiture package would prevent HCA itself from pursuing its high-acuity healthcare strategy. HCA had argued that its patients benefitted significantly from the tight network that it operated enabling a seamless transition from one facility to another. It also argued that it benefitted from scale economies, including the ability to support specialized facilities. It told us, for example, that staff development and skill would be enhanced by continual experience of the same area of care, such as breast cancer care.

2.119 We thought that the unique benefits of the pathways between HCA's facilities had been overstated since we thought that they applied mainly to cancer treatment and even then only to a limited range of hospitals including the Harley Street Clinic and LOC. Finally, we thought that the growth in the size of the London market would support the provision of specialist services even within an HCA group that held a smaller share of the market.

2.120 BMI told the CC that it was in the process of implementing a competitive strategy that involved: [REDACTED].

2.121 We did not see any rationale for BMI to change its strategy of [REDACTED], in the case in which the CC required BMI to divest some of its hospitals. [REDACTED], BMI would have the same incentives to [REDACTED].<sup>73</sup>

2.122 In relation to [REDACTED]. Indeed, we thought that in a situation where BMI (and other operators) faced a higher level of competition, it was likely to have greater incentives to improve efficiency in order to maintain profits despite downward pressure on prices.<sup>74</sup> We note BMI's argument that [REDACTED].

2.123 Finally, we considered whether BMI itself or a purchaser of its assets would be likely to follow a strategy that was different from that set out by BMI such that it would impair quality of care or patient service. We considered that BMI would have no reason to change its current strategy following divestiture. Although BMI's cash flows would be reduced by the decline in the number of hospitals, it would also have fewer hospitals on which to focus its capital expenditure. We did not, therefore, consider that this would be likely to undermine its commercial strategy.

2.124 As regards the ability of a purchaser to pursue the same strategy as BMI, we reasoned that a suitable purchaser would have both the requisite expertise and [REDACTED] (since this would be a condition set by the CC). Such a purchaser would, therefore, be likely to be able to [REDACTED].

---

<sup>73</sup> [REDACTED]

<sup>74</sup> See paragraphs 2.125 to 2.137 below for a discussion of BMI's (and HCA's) arguments regarding economies of scale.

- *Loss of economies of scale*
- ○ *BMI*

2.125 We next consider BMI's points relating to economies of scale. BMI told us that its remaining hospitals would have to cover the £[§] million of central costs that it currently recharges to the hospitals that have been proposed for divestiture. In addition, BMI claimed that it would not be able to reduce its remaining central costs (which are not recharged to the sites) in proportion to the loss of EBITDA from the divested facilities. It assumed that if it were to be forced to divest hospitals contributing [§] per cent of its total revenues, it believed that it could save [§] per cent of its 'infrastructure costs', a saving of £[§] million in FY16. Therefore, BMI estimated that its fixed costs would increase by approximately £[§] per hospital, or £[§] million across the remaining estate, which it estimated would be equivalent to a [§] per cent increase in its prices. BMI provided a break-down of its forecast total central costs over the FY14 to FY18 period, showing its position both with divestitures and in the absence of any divestitures.

2.126 In the first instance, we note that our insured price analysis<sup>75</sup> indicates that to the extent that any group-level economies of scale are achieved by BMI, customers do not appear to be benefiting from them at the moment in terms of prices, as BMI charges higher prices than its national competitors even though it is materially larger. We therefore consider it is unlikely that such economies give rise to RCBs that we should take account of as being extinguished by divestiture. However, we thought that the loss of any economies of scale on an ongoing basis may be considered to represent a relevant cost of a divestiture remedy to be taken into account in our assessment of proportionality.

---

<sup>75</sup> See [provisional findings](#), Appendix 6.12.



2.127 In considering BMI's submissions on economies of scale, we first made some high-level adjustments to reflect the revised package of proposed divestitures, ie seven sites rather than 11 sites, using information on central costs provided by BMI.<sup>76</sup> On the assumption that the seven divested sites are of average size and that none of the central costs can be saved, this suggests that there is a total of £[X] million of central costs that in theory may need to be supported by the 61 remaining sites, equivalent to £[X] per site. This is approximately equivalent to a [X] per cent impact on the prices charged to private patients. However, BMI suggested that it would be able to reduce its central costs by approximately [X] per cent in response to the divestiture of hospitals contributing [X] per cent of total revenue. If we make a similar assumption, ie that BMI could reduce its central costs by [X] per cent in response to a [X] per cent decline in total revenues,<sup>77</sup> the total incremental central costs that would need to be covered by the remaining hospital sites would be approximately £[X] million, which is equivalent to a [X] per cent increase in the price charged to private patients, on the assumption that the increase in costs is passed through in full.

TABLE 3 Impact of divestitures on BMI central costs (per site)

	<i>FY14 (no cost savings)</i>	<i>FY14 pro-forma (cost savings)</i>
Total central costs	[X]	[X]
Costs per site (68 sites)	[X]	[X]
Total costs attributable to 7 divested sites	[X]	[X]
Costs per site (61 sites)	[X]	[X]
Incremental cost per site	[X]	[X]
Potential impact on prices	[X]	[X]

Source: CC analysis.

2.128 We thought that BMI's estimate that it could save around [X] the proportion of central costs as the proportion of revenue lost represented a lower-end figure and that, in the longer-run, it should be able to save a larger percentage of the central

<sup>76</sup> [X]

<sup>77</sup> In FY11, the seven sites accounted for approximately £[X] million of revenue, out of a total of £[X] million (excluding Care and Transform), ie [X] per cent.

costs. For example, [X]. However, this suggests that the absolute scale of BMI is not critical for achieving a competitive cost structure and we expect that BMI would make greater cost savings than it has assumed in its submissions to the CC. In our quantification of the net present value of our remedies, therefore, we have not included any loss of economies of scale in our base case as we do not expect any such loss to be significant on an ongoing basis. However, in our 'downside' case, we have included £2 million a year of such losses.

2.129 We noted that, if there were significant economies of scale (at the group level) in the provision of private healthcare services, we would expect that advantaged suitable purchasers of BMI's hospitals would include national or international groups that would ensure that divested hospitals would continue to benefit from economies of scale.

2.130 In addition to the potential price/cost impacts of divestiture, we considered whether the quality of care provided to patients was likely to fall if BMI were forced to divest its hospitals due to a loss of economies of scale. We thought that it was relevant to consider the potential quality impact on both those hospitals that were divested and the remaining hospitals. We reviewed the most recent CQC/HIS/HIW reports for each of BMI's hospitals in the UK and found that in 15 cases (out of 62) these regulatory bodies had required BMI to improve some aspect of the care. This compared with three requirements on Spire's 38 hospitals, one requirement on Nuffield's 31 hospitals and two requirements on Ramsay's 25 hospitals. Although this analysis provides a relatively crude measure of the quality of hospital operators, it suggests that the economies of scale that arise from the ownership of a large chain of hospitals do not necessarily increase the quality of the facility. We do not believe, therefore, that there is any evidence to suggest that a loss of economies of scale would have any impact

on the quality of care provided to patients, either at the remaining BMI facilities that were not divested or at those facilities that were divested to a different operator. [REDACTED]

2.131 Therefore, to the extent that economies of scale exist at the group-level within BMI, we considered that these are not passed on to customers in terms of quality of care. We therefore consider that such economies do not give rise to RCBs that we should take account of as being extinguished by divestiture.

○ ○ *HCA*

2.132 HCA told us that at least £[REDACTED] million of its central costs that were allocated to its London Bridge and Princess Grace hospitals would need to be covered by its remaining facilities in the case of divestiture, with a further £[REDACTED]<sup>78</sup> costs not currently being allocated but that would also contribute to an increase in fixed costs. HCA also suggested that it would face increased unit costs for [REDACTED] but it did not quantify this effect and therefore estimated that the £[REDACTED] million of central costs should be considered to be conservative. HCA estimated that it would generally be able to save between [REDACTED] and [REDACTED] per cent of the central costs allocated to these two hospitals following their divestiture (excluding [REDACTED]), with between £[REDACTED] million and £[REDACTED] million of (additional) central costs spread across its remaining facilities.<sup>79</sup> HCA said that this cost alone would result in a [REDACTED] per cent increase in the average cost per patient at the remaining facilities, without factoring in the additional cost categories HCA had identified.

2.133 We thought that HCA's assumptions regarding central cost savings were highly conservative and therefore likely to substantially underestimate the cost savings that could be made. For example, HCA suggested that it [REDACTED]. HCA also estimated that it

---

<sup>78</sup> [REDACTED]

<sup>79</sup> HCA's total FY12 revenues were approximately £[REDACTED] million, of which around [REDACTED] per cent were generated by London Bridge and the Princess Grace, leaving around £[REDACTED] million of revenue at the remaining HCA facilities.

would be able to save between [X] and [X] per cent of the laboratory costs allocated to the London Bridge and Princess Grace hospitals in the case of divestiture. These costs were comprised of staff salaries ([X] per cent), medical supplies ([X] per cent) and external test fees ([X] per cent). We do not consider either of these assumptions to be reasonable given the size of the proposed divestiture package, which should allow for a more significant change in the size of the central administration team, or the nature of the laboratory costs, which we would expect to be largely variable.

2.134 In addition, we thought that the recent financial performance of the business did not appear to support HCA's approach to estimating its loss of economies of scale. [X]<sup>80</sup> However, the EBITDA margin of the business has remained broadly constant (at around [X] per cent) since FY09.<sup>81</sup> The fact that EBITDA margins have remained constant despite substantial growth suggests that the business does not, in fact, enjoy the level of economies of scale (or scope) suggested by HCA's analysis of the proportion of central costs that it could save following a divestiture. In particular, we note that divestiture would result in a reduction in the number of facilities operated which could generally be expected to facilitate step changes in cost savings. We considered that this review of HCA's recent past performance indicated that at least a large proportion of the central costs associated with these facilities could be saved by HCA following divestiture.

2.135 On the assumption that HCA allocates central costs between its facilities in proportion to the revenue they generate, we estimated that total central costs for the

---

<sup>80</sup> [X]

<sup>81</sup> The EBITDA margin has been calculated as EBITDA less VAT divided by revenue.

business were approximately £[X] million (including [X] costs).<sup>82</sup> The London Bridge and Princess Grace hospitals comprise around [X] per cent of HCA's total revenues. If we apply the same assumption as made by BMI which, as noted above, we consider to be conservative, this suggests that HCA could save at least [X] per cent of these £[X] million of central costs, or £[X] million a year, compared with HCA's estimates of £[X] million savings a year. This analysis suggests that an upper end estimate of HCA's loss of economies of scale would be £[X] million per year. However, as was the case for BMI, we expect that HCA would in fact be able to make much more significant cost savings following a reorganization of its operations. In our quantification of the net present value of our remedies, therefore, we have not included any loss of economies of scale in our base case as we do not expect any such loss to be significant on an ongoing basis. However, in our 'downside' case, we have included [X] a year of such losses.

2.136 We noted that if there were significant economies of scale (at the group level) in the provision of private healthcare services, we would expect that advantaged suitable purchasers of HCA's hospitals would include national or international groups who would ensure that the divested hospitals would continue to benefit from economies of scale.

2.137 Finally, we note that we would expect that economies of scale would result in lower prices being charged, which is not the case as HCA has charged prices approximately [X] than those of TLC (in 2011) which operates one hospital. HCA also has not demonstrated that it delivers significantly higher quality of service than its close competitors (see Appendix 2.1). To the extent that economies of scale exist within HCA, we considered that these are not passed on to customers in either prices or

---

<sup>82</sup> HCA did not provide a quantification of its total central costs and this is not clear from its accounts. This £[X] million estimate has been calculated as £[X] million of central costs plus £[X] costs scaled up on the basis that LBH and PG comprise approximately [X] per cent of the HCA group.

quality of care. We therefore consider that such economies do not give rise to RCBs which we should take account of as being extinguished by divestiture. However, as set out in paragraph 2.135, we have included up to £5 million a year of such costs to the business in our quantification of the net present value of our remedies as a 'downside' case.

- *Divestiture at below fair market value*

2.138 As set out in paragraph 2.80, there is significant evidence to suggest that a large number of potential purchasers are likely to be interested in acquiring UK private hospital assets, such that we consider it likely that BMI could achieve a fair market value for any assets that it was required to sell. [REDACTED]<sup>83</sup>

2.139 BMI further suggested that any decline in prices that result from divestitures and the consequent increase in Bupa's relative market power will contribute to the risk that it will be required to sell its hospitals at an under-value. However, we do not consider it appropriate to take into account in our proportionality assessment loss of value that accrues to a business as the result of divestiture to the extent that this is caused by future financial performance no longer reflecting an AEC from common ownership. The CAT supported this view in its 2012 BAA decision.<sup>84</sup>

- *Transaction costs*

2.140 BMI told the CC that the divestiture of the (initial) divestiture package of 11 hospitals would result in transaction costs of £[REDACTED] million, comprised of financial advisor fees

---

<sup>83</sup> [REDACTED]

<sup>84</sup> 'In performing a proportionality analysis ... we consider that it is appropriate that the fair value of Stansted should be assessed by the value the market will give it after there has been an appropriate opportunity to market it. **This value will take account of its performance to an appropriate extent ie in circumstances undistorted by the AEC of common ownership and as assessed by the market, and BAA will receive the appropriate compensating payment (the market price) for giving up an asset with the potential for such future performance.** (Emphasis added). The CC cannot be expected to be more perspicacious than the market in predicting and assessing the impact of future performance.' *BAA v Competition Commission*, February 2012, paragraph 78.

to £[REDACTED] million to £[REDACTED] million, legal fees of around £[REDACTED] million,<sup>85</sup> monitoring trustee costs of £[REDACTED], and internal costs of staff transaction support of around £[REDACTED]. [REDACTED]

2.141 HCA estimated that it would incur transaction costs of between £[REDACTED] million and £[REDACTED] million if it were required to divest two of its hospitals, comprising M&A fees of between £[REDACTED] million and £[REDACTED] million, legal fees of between £[REDACTED] and £[REDACTED], due diligence fees of between £[REDACTED] and £[REDACTED] and various other costs amounting to £[REDACTED]. HCA did not quantify any reorganization costs but it did suggest that we should take into account the transaction costs of the purchaser of its hospitals. We did not think that this was appropriate, since a purchaser could be expected to reflect its own costs in its bid for the business.

2.142 In order to review the reasonableness of these costs estimates, we asked Nuffield to provide us with details of the transaction costs it incurred in selling nine of its hospitals to BMI in 2008. We reasoned that this transaction was of an approximately similar size to the divestiture package specified for BMI. Nuffield told us that it incurred total costs of approximately £4.3 million, comprised of £[REDACTED] million of legal fees, £[REDACTED] million fees for financial advice, £[REDACTED] of project management and bonus costs, and £[REDACTED] of IT separation costs.

2.143 We observed that BMI and HCA suggested a relatively similar level of total fees but that the split of the fees between different types of advice was significantly different. [REDACTED] We thought that the total level of fees suggested by both BMI and HCA were within a reasonable range, although we considered that the reduced divestiture package proposed for BMI would reduce its transaction fees proportionately. We

---

<sup>85</sup> This figure includes vendor due diligence.

have, therefore, taken into account transaction fees of £5 million for HCA and £4 million for BMI.<sup>86</sup>

2.144 [REDACTED]<sup>87</sup>

2.145 We thought that [REDACTED] reorganization [REDACTED] costs would be incurred as a direct result of our divestiture remedy and the need to reduce the central business functions to reflect the smaller size of the business. We noted that [REDACTED]. On the basis that only seven sites will be divested but that we think BMI will be able to save substantially all the associated central cost in the longer-run, we have estimated that the business will incur total [REDACTED] reorganization costs of approximately [£4–£6 million]. HCA did not provide an estimate of the costs that it expected to incur in reorganizing its operations following the divestiture of two of its hospitals; however, we estimated that these would be approximately proportionate to those incurred by BMI, or around [£7–£9 million].<sup>88</sup>

○ *Quantification of costs of divestitures*

2.146 In conducting our cost-benefit analysis, we have taken into account the transaction costs of selling the hospitals, the reorganization [REDACTED] costs that the private hospital operators are likely to incur following divestiture in order to re-configure their businesses in line with their reduced scale and, in our down-side case, we have included the cost of losing economies of scale on an ongoing basis. These costs are included in our estimate of the net present value of our divestiture remedies in paragraphs 2.160 to 2.163.

---

<sup>86</sup> [REDACTED]

<sup>87</sup> [REDACTED]

<sup>88</sup> On the basis that BMI would incur around [£4–£6 million] of [REDACTED] reorganization costs to save around £[REDACTED] million of central costs, we estimate that HCA would incur around [£7–£9 million] of redundancy/reorganization costs to save around £[REDACTED] million of central costs.



TABLE 4 CC estimates of costs of divestiture

	Transaction costs £m	Other one-off costs (reorganization costs) £m	Ongoing loss of economies of scale	
			Base case £ per year	Down-side case £m per year
BMI	4	[4–6]	0	2
HCA	5	[7–9]	0	5

Source: CC analysis.

- *Benefits of divestiture*

2.147 We considered that there were likely to be two main benefits resulting from the divestiture package specified in Table 2, namely a reduction in the prices charged to private patients at both the divested hospitals and those retained by BMI and HCA, and an improvement in the quality of private healthcare services in the local markets where divestitures are required. In this section, we consider each of these benefits in turn, as well as BMI's argument that any benefits of divestiture would accrue to a relatively small proportion of patients.

- *Reduction in prices*

2.148 In Appendix 2.5 we have set out in detail the approach that we have adopted in estimating the likely reduction in prices that would result from our divestiture remedies. We reasoned that, in local areas outside central London, the most appropriate method of estimating the likely change in total revenues resulting from a change in concentration would be to apply the coefficient range identified in our PCA analysis<sup>89</sup> to the changes in the weighted average market share of the hospitals to identify the price effect for both self-pay and insured patients. We thought that this approach was reasonably conservative given the discounts offered to insurers by some private hospital operators in return for recognition (or exclusivity) in certain areas.<sup>90</sup>

<sup>89</sup> This range was a reduction in price of between 3 and 4 per cent in response to a 20 percentage point decline in the weighted average market share of a hospital (group).

<sup>90</sup> For example, AXA PPP told us that BMI gave it a [X]; and [X].

2.149 We then estimated a range of potential effects by applying this change in prices to inpatient revenues only, to give a lower estimate, and to all private patient revenues, to give an upper estimate. Our base case estimate is based on applying this price reduction to the combined private inpatient and day-case revenue of the hospitals. Table 5 shows the likely impact on revenues of the divestiture of the smallest divestiture package we have specified.<sup>91</sup> Our base case estimates indicate total revenue benefits to customers of between £4.4 million and £5.9 million from the proposed divestiture package specified for BMI (ie the seven hospitals), and of between £9.5 million and £12.7 million for the proposed divestiture package for HCA (ie the Princess Grace and London Bridge hospitals).

TABLE 5 Impact of divestitures on total private patient revenues

Hospital divested	Revenue reduction (£'000)		
	Inpatient only	Inpatient & day case ('Base case')	Inpatient, day case & outpatient
[X]	[X]	[X]	[X]
[X]	[X]	[X]	[X]
[X]	[X]	[X]	[X]
[X]	[X]	[X]	[X]
[X]	[X]	[X]	[X]
[X]	[X]	[X]	[X]
HCA London Bridge & HCA Princess Grace	[X]	[X]	[X]

Source: CC analysis.

Note: These estimates are based on FY11 revenue figures, including the split between inpatient, day-case and outpatient treatment and NHS- and privately-funded patients.

2.150 As set out in Appendix 2.5, we believe that these estimates may be conservative since they do not take into account any benefit to patients arising from an increase in demand resulting from the lower prices charged.

○ *Competition and investment in quality improvements and innovation*

2.151 We observed specific examples of competition leading directly to improvements and investment in service quality and the introduction of new techniques.

<sup>91</sup> That is, this assumes that BMI chooses to sell the hospitals with the lowest profits where it has a choice.

- 2.152 We set out in our case study on Circle's entry into Bath the example of new endoscopes being purchased by BMI's Bath clinic as a result of requests from consultants to replace the Clinic's 10- to 13-year-old equipment. The consultants concerned pointed out that both Circle's new hospital in Bath and the local NHS hospital had modern equipment.<sup>92</sup>
- 2.153 In our case study on Edinburgh, Spire told us that it had invested in optometry equipment in order to better compete with the Edinburgh Clinic for patients.<sup>93</sup> We also saw Spire in Edinburgh invest in a new modular theatre and CT scanner at its Murrayfield hospital when it knew that Circle was considering entry into the Edinburgh market.<sup>94</sup>
- 2.154 In our case study on TLC's Cancer Centre we showed how TLC invested heavily in radiotherapy to match investments made at the Harley Street Clinic and Bupa Cromwell.<sup>95</sup>
- 2.155 HCA told us that it had invested in 'bedside medication verification', at a cost of £[REDACTED] million, [REDACTED].
- 2.156 These examples show that local rivalry stimulates a degree of competition on quality and, therefore, we expect that an increase in rivalry resulting from divestiture to a suitable purchaser or purchasers in a relevant area would result in increased competition on quality (not just on price) and an improvement in the quality of hospital services over time. We have not sought to quantify this benefit for inclusion in our NPV analysis of the costs and benefits of the divestiture remedy as we do not believe that

---

<sup>92</sup> [Provisional findings](#), Appendix 6(1), paragraph 47.

<sup>93</sup> [Provisional findings](#), Appendix 6(2), paragraph 67.

<sup>94</sup> [ibid](#), paragraph 44.

<sup>95</sup> [Provisional findings](#), Appendix 6(3)-11, paragraphs 33-36.

this benefit is amenable to quantification.<sup>96</sup> However, we consider that the advantages to customers of greater rivalry on quality and innovation are likely to become substantial over time.

*Proportion of patients affected*

2.157 In addition to considering the costs that would be caused by divestitures, BMI also argued that the CC should take into account when determining the proportionality of its divestiture remedies the disruption to patients as the result of divestiture. BMI suggested that, in most cases, the potential price benefits of divestiture would affect only a small proportion of patients, ie private inpatients, excluding those insured by Bupa, who generally comprise fewer than [X] per cent of total patients, whereas the potential disruption would have an impact on the remaining [X] per cent or more of patients who are not private inpatients. BMI explained that the disruption caused to these patients would result from the uncertainty created by the divestment process, the loss of consultant confidence, [X], the inability of these patients to benefit from BMI's commercial strategy and the loss of efficiencies. BMI said that a forced divestment would not be comparable to the sale of hospital in an M&A process, where the process can be kept confidential to ensure a smooth transition.

2.158 We have addressed BMI's arguments regarding [X], commercial strategy and loss of efficiencies above and consider that any adverse effect on patients from these proposed factors would not be material. We also note that, although inpatients comprise a relatively small proportion of total patient visits to BMI hospitals, we do not agree with BMI's representation of the proportion of patients that will benefit. In the first instance, we note that we did not find that Bupa had fully countervailing buyer power vis-à-vis the private hospital operators. Therefore, we consider that it is

---

<sup>96</sup> For example, investment in less invasive surgical techniques may reduce recovery times for patients, which represents a clear improvement in quality but cannot easily be quantified or valued for our purposes.

not appropriate to exclude Bupa's patients from the group of those who would benefit from divestiture remedies. Second, we observed that the number of outpatient visits is not the same as the total number of outpatients using a hospital as many patients will have several outpatient visits associated with their course of treatment.<sup>97</sup> Third, patients that visit a hospital on an outpatient basis and those that are admitted for treatment will overlap significantly, such that lower inpatient prices or better quality will also benefit many 'outpatients'. For example, the standard treatment pathway for a number of common inpatient procedures would include an initial outpatient consultation, one or more diagnostic tests, the procedure and one or more follow-up consultations. In this case, the same patient generates four or more 'visits' only one of which is inpatient. However, the three outpatient visits all relate to a patient who benefits from competition in the market for inpatient healthcare services. Fourth, our insured pricing analysis includes day case admissions and supports the finding that weak competitive constraints in local areas result in higher prices to insurers (and thereby insured patients). This indicates that the relationship between prices and concentration is likely to hold for day case treatments, as well as inpatient treatments, such that these (day case) patients would also benefit from divestitures. Finally, we note that inpatient revenues account for around 40 to 45 per cent of total hospital revenues and we believe that this—and not only patient numbers as BMI suggests—is relevant to a consideration of proportionality.

#### *Proportionality assessment*

- 2.159 In order to assess the proportionality of our divestiture package, we have taken into account both price/cost factors and the potential impact on quality. In the case of the former, we have quantified the costs and benefits and carried out a net present value

---

<sup>97</sup> While some patients may also have several inpatient procedures, this will be significantly less common, distorting the relative proportions of inpatients and outpatients.

calculation, whereas, in the case of the latter, we have conducted a qualitative assessment.

- *Net present value of divestitures*

2.160 We estimated the net present value of our proposed package of divestiture remedies in each case. We note that this estimate only takes into account the *price* benefits of divestiture and does not account for any quality and/or innovation benefits that we expect would result from the dynamic process of rivalry between competing hospital operators. As a result, we consider that this analysis is likely to materially understate the overall benefits to customers of our divestiture remedies, ie is a conservative estimate of the net benefits.

2.161 We have made a number of assumptions in estimating the NPV of our divestiture remedies, including:

- (a) The one-off costs of divestiture are approximately [£8–£10 million] for BMI and [£12–£14 million] for HCA, as set out in Table 4. We reasoned that the transaction costs would be incurred in the first year, while the reorganization costs would be incurred equally across the first two years following divestiture.
- (b) The ongoing costs of divestiture—associated with a loss of economies of scale—are zero in our base case for all years and £2 million a year for BMI and £5 million per year for HCA in our downside case.
- (c) Our base case estimates of the price benefits of our remedies are between £4.4 million and £5.9 million a year for BMI and between £9.5 million and £12.7 million per year for HCA. In each case, we have used the midpoint of these ranges in our base case NPV calculation. In addition, we have used our upper-end estimate of the price benefit that may be achieved in the London market (of

£29.5 million a year)<sup>98</sup> as an upside case for HCA. We thought that the price benefits of divestiture would come through partly in the second year following divestiture and fully from the third year onwards, since we have specified that the insurers should continue to recognize the divested hospitals on the same terms for 18 months following divestiture.

(d) We projected the costs and benefits over a 20-year period, as appropriate, without making adjustments for inflation. Our estimates of the annual benefit and of the ongoing costs are based on current values. We consider that these benefits and costs would likely change over time in line with inflation. As such, we consider it appropriate to treat those figures as if in real terms, and hence there is no need to adjust value for inflation and to use nominal discount rates rather than real discount rates. We considered that a 20-year period was appropriate in view of the longevity of hospital facilities and the high barriers to entry we have identified and which are likely to continue.

(e) We have used a discount rate of 3.5 per cent, in line with the Treasury Green Book.

2.162 The results of our analysis (base case and downside case) are set out in the table below. In both scenarios, the benefits of divestiture outweigh the costs, indicating a positive net present value of our remedy even taking into account the potential loss of economies of scale. As discussed in paragraph 2.160, we consider that these are likely to be highly conservative estimates of the net benefits to customers from our divestiture remedies as they do not take into account the quality and innovation benefits that we expect to result from increased competition.

---

<sup>98</sup> See Appendix 2.5 for full details of our approach to estimating the price benefits of divestitures.

2.163 For HCA, we also estimated an ‘upside’ case, using a revenue reduction of £29.5 million a year (see Appendix 2.5 for our reasoning). In this case, the NPV of our divestiture remedy for HCA is significantly higher, between £294 million and £365 million over the next 20 years (excluding any quality/innovation benefits).

TABLE 6 NPV associated with proposed divestiture packages

	<i>£ million</i>	
	<i>Net present value of divestitures</i>	
	<i>Downside case</i>	<i>Base case</i>
BMI	19.2	57.0
HCA	38.3	129.7

Source: CC analysis.

### *Conclusions on proportionality*

2.164 We considered the proportionality of our divestiture remedy packages in relation to BMI and HCA separately.

#### *BMI*

2.165 We took into account the quantifiable potential costs and benefits of our divestiture package. We noted that the net present value of the divestitures was clearly positive (and substantial) on our base case at £57 million and remained positive even when we took into account potential ongoing losses of economies of scale (£19.2 million). This indicates that divestitures are likely to be beneficial financially to customers across a range of assumptions.

2.166 [✂]

2.167 We examined BMI’s arguments that divestiture would undermine the quality of services it provided to patients, due to a loss of economies of scale and/or ability to invest in developing the estate, as well as its views that a purchaser may not invest in the same high acuity strategy or operate its facilities as well with resultant detriment



to patients. However, we concluded that in BMI's case there were no reasons to believe that divestiture would damage either the quality or range of healthcare services provided to patients. Indeed, we noted that [§]. Finally, given the limited number of proposed hospital divestitures, we did not think that the financial impact on BMI would be sufficient to change its investment strategy with respect to its remaining hospitals.

2.168 We found evidence that increased competition in local areas tends to increase investment in new and/or better equipment in order to attract consultants. This was demonstrated in a number of cases, including as a result of Circle's entry into the Bath market. We reasoned that, in combination with our prohibition on the payment of incentives to clinicians, divestiture was likely, therefore, to improve the quality of healthcare services in the local areas in which competition was increased. While it is not possible to quantify this benefit to patients, we consider that it is likely to be significant and is incremental to the price benefits taken into account in our NPV analysis.

2.169 We concluded, therefore, that our proposed divestiture package for BMI met the criteria for a proportionate remedy in that:

- (a) it would be effective in achieving its legitimate aim, ie the increase in competition in the market for privately-funded healthcare services in a number of local areas in the UK (outside central London);
- (b) it is not more onerous than needed to achieve its aim, ie there is no smaller package of divestitures or other (non-structural) remedies that would achieve this same aim;
- (c) it is the least onerous to the extent that there is a choice between several effective measures; and

(d) it does not produce disadvantages which are disproportionate to the aim since the likely price and quality benefits of requiring BMI to divest seven of its hospitals exceed the costs substantially.

#### *HCA*

2.170 We took into account the quantifiable potential costs and benefits of our divestiture package. We noted that the net present value of the divestitures was substantial on our base case at almost £130 million, and remained positive even when we took into account potential ongoing losses of economies of scale (£38.3 million). In addition, in the case of HCA, we noted very significant potential upside in terms of the price benefits to patients as a result of introducing more competition into the London market.

2.171 We examined the evidence submitted by HCA in relation to the quality of the services offered and the innovation that it had brought to the market. We thought that there was a reasonable level of evidence that HCA provided good quality and high acuity services and that it had introduced a range of new treatments into the private market in London. However, we did not think HCA's submissions supported its contention that a competitor would have neither the incentive nor the ability to follow a similar strategy or that HCA itself would be prevented from doing so were it required to make the divestitures proposed. Indeed, we thought that increased competition in the market would be likely to stimulate further innovation and quality improvements rather than less. While it is not possible to quantify these benefits, we consider that they are likely to be significant and incremental to the price benefits taken into account in our NPV analysis.

2.172 We concluded, therefore, that our proposed divestiture package for HCA met our criteria for a proportionate remedy in that:

- (a) it would be effective in achieving its legitimate aim, ie the increase in competition in the market for privately-funded healthcare services in central London;
- (b) it is not more onerous than needed to achieve its aim, ie there is no smaller package of divestitures or other (non-structural) remedies that would achieve this same aim; and
- (c) it is the least onerous to the extent that there is a choice between several effective measures.

2.173 It does not produce disadvantages which are disproportionate to the aim since the likely price and quality benefits of requiring HCA to divest two of its hospitals exceed the costs substantially.

#### *Conclusion on divestiture remedy*

2.174 We propose, therefore, that BMI and HCA be required to divest the following hospitals to suitable purchasers:

(a) BMI:

- (i) either the Clementine Churchill or Bishops Wood hospital;
- (ii) either Kings Oak or Cavell hospital;
- (iii) either Chiltern or Shelburne hospital;
- (iv) Chelsfield Park and either Shirley Oaks or Sloane hospitals;
- (v) either Saxon Clinic or Three Shires hospital; and
- (vi) Highfield hospital;

(b) HCA:

- (i) both the Princess Grace and the London Bridge hospitals.

### ***Remedy 3: restrictions on expansion***

#### *Introduction*

2.175 This remedy would address the AECs by, following a case by case review, giving the OFT/CMA the power to prohibit an existing private hospital operator facing weak competitive constraints from acquiring the right to manage a local PPU. The remedy would be applicable throughout the UK.

2.176 In our provisional findings we identified two structural features in the provision of privately-funded healthcare by hospitals:

(a) high barriers to entry for full service hospitals; and

(b) weak competitive constraints in many local markets including central London.<sup>99</sup>

Together these give rise to AECs in the markets for hospital services that are likely to lead to higher prices being charged by hospital operators to self-pay patients and to higher prices being charged by HCA, BMI and to a lesser extent Spire to PMIs for insured patients.<sup>100</sup>

2.177 We said in our provisional findings that the high barriers to entry arise from the high levels of sunk costs required to set up a hospital with inpatient services, the significant capital costs of building and equipping a full service hospital combined with flat demand for private services and the fact that many local markets were only large enough to support a small number of efficiently sized hospitals.

2.178 We provisionally found that because PPUs are generally co-located with the Trust's NHS facilities and benefit from their infrastructure and support facilities, partnering with a NHS Trust to manage a PPU may offer a low-risk means of market entry for private hospital operators. We also provisionally found that the number of PPUs may

---

<sup>99</sup> [Provisional findings](#), paragraph 10.3.

<sup>100</sup> [Provisional findings](#), paragraph 6.294.

increase as a result of the lifting of the cap on the amount of private income a Trust could earn as a result of the [Health and Social Care Act 2012](#).

2.179 However, we said that if an existing private hospital operator, which faced weak competitive constraints, entered into a partnership or other business agreement with a Trust to manage a PPU, this would prevent a new entrant from doing so and thereby prevent market concentration in that area being reduced. We therefore proposed a market opening measure (Remedy 3), which would make it easier for a new entrant to partner with an NHS Trust to operate a PPU.

2.180 In our Remedies Notice we said that this remedy may in particular mitigate the AECs in the areas that we had characterized as ‘Single’ or ‘Duopoly’<sup>101</sup> areas, where we considered divestment remedies would be ineffective. We thought that it would be appropriate to prohibit private hospital operators outright from operating PPUs in the areas in which we had found that they faced weak competitive constraints, including in Single and Duopoly areas.

2.181 For the reasons set out below we now consider that:

- (a) since competitive conditions could change, it may not be appropriate to apply this remedy only to the areas where we found that private hospital operators faced weak competitive constraints at the time we published our provisional findings; and
- (b) an outright prohibition from operating a PPU in areas where private hospital operators face weak competitive constraints would be inappropriate and that instead they should be subjected to scrutiny on a case-by-case basis.

---

<sup>101</sup> As defined at paragraph 24 of the [Remedies Notice](#).

### *How the remedy would address the AEC*

2.182 The remedy would address barriers to entry by restricting an existing private hospital operator facing weak competitive constraints from acquiring the right to manage a local PPU. The remedy would therefore increase local rivalry by facilitating market entry to the local area, or market expansion of a smaller existing operator, through a partnership with the NHS trust to operate the PPU.

2.183 While some such arrangements may be subject to review under existing merger control, we noted that some recent arrangements did not because they were not ‘relevant merger situations’ as required under Part 3 of the Act (see paragraph 2.224). It is therefore intended that this remedy would complement merger control provisions (UK or EU) and apply only to those arrangements for the management of PPUs which were outside the merger regimes.

### *What parties told us*

2.184 We asked parties for their views on the effectiveness of the proposed Remedy 3 as proposed in the Remedies Notice, including whether it would be practicable for a hospital operator with no local facilities to operate a PPU on behalf of a Trust, whether the remedy would give rise to unintended consequences, whether customer detriment would arise if, for example, no new entrant appeared and what arrangements for monitoring and enforcement would be necessary.

### *PMIs*

2.185 Bupa welcomed the proposed Remedy 3 but expressed certain concerns about its limitations.<sup>102</sup> It first noted that the remedy would only address the risk of further concentration in Single and Duopoly areas rather than tackling the extent of existing concentration.

---

<sup>102</sup> [Bupa response to Remedies Notice](#), paragraph 4.170 ff.

- 2.186 It said that lack of competition in Single and Duopoly areas would continue until the PPU reached sufficient scale and that entry on this scale remained uncertain. The CC could therefore not rely on emerging competition from PPUs resolving AECs in these areas.
- 2.187 Bupa questioned whether the proposed Remedy 3 should apply only to Single and Duopoly markets, arguing that the remedy should also apply to central London. Finally, it said that owners of affected hospitals should be clearly warned about which current/potential PPUs would fall within their catchment areas.
- 2.188 AXA PPP supported the proposed Remedy 3.<sup>103</sup> It said that, if set up and run appropriately, PPUs were able to offer some competition to stand-alone private hospitals. It said that PPUs had advantages in terms of their cost base and buying power for consumables and it would expect prices charged to reflect this and thus be competitive against other private provision, providing contestability in Single and Duopoly areas.
- 2.189 When asked which body should monitor and enforce this remedy, AXA PPP said that they had a slight preference for Monitor rather than the OFT/CMA.
- 2.190 PruHealth agreed that in Single and Duopoly areas incumbents should be prevented from partnership with NHS facilities.<sup>104</sup> It said that this view was based on its exposure to significant cost increases when an incumbent with Duopoly market power had partnered with an NHS PPU.
- 2.191 Aviva, while supporting the proposed Remedy 3, did not believe that it was likely to have a significant, immediate impact on the competitive constraints faced by

---

<sup>103</sup> [AXA PPP response to Remedies Notice.](#)

<sup>104</sup> [PruHealth response to Remedies Notice.](#)

hospitals in Single or Duopoly areas. Aviva said that PPUs currently only accounted for a small portion of its total spend and it was not aware of any immediate plans for PPUs to expand into Single or Duopoly areas.

2.192 WPA said that it was not convinced that the proposed Remedy 3 would be particularly effective in changing the practices of those providers which were abusing market power. It said that hospital operators which were currently making excessive profits would continue to use their market power to ensure high prices in any new PPU contract they took on. However, the ability for them to continue to do this would only be undermined if the CC's other remedies were successful in reducing prices to a fair level.

2.193 Simplyhealth was generally supportive of the proposed Remedy 3 but unable to comment in detail as it was not aware of the location of the Single and Duopoly areas identified by the CC.<sup>105</sup> It thought that Monitor, as the sector regulator, would be the most appropriate body to oversee and enforce the remedy.

#### *Hospital operators*

2.194 BMI said that the proposed Remedy 3 was unnecessary as the CC's analysis of barriers to entry was insufficiently robust to support the provisional finding that high barriers to entry were a feature of the private healthcare market. BMI said that, without prejudice to this view, it accepted that in principle the remedy would be both effective and proportionate at resolving any AEC that was found to result from high barriers to entry and weak competitive constraints in many local markets. In particular, BMI said that, when compared with the CC's proposed divestment remedy, Remedy 3 would instead be much more effective in achieving the CC's aims. It said that a key advantage of this remedy compared with other remedies

---

<sup>105</sup> [SimplyHealth response to Remedies Notice](#), page 8.



involving divestment and interference in contractual freedom was that it focused on barriers to entry and directly addressed the underlying feature that the CC had supposedly identified, rather than just the adverse effects arising from the feature. Further, BMI said Remedy 3 would also be far less onerous on hospital operators, who would not be required to sell large parts of their business [§], undermining ongoing commercial strategies and removing efficiencies from the businesses, and also far less detrimental for patients.

2.195 It said that PPU outsourcings were likely to be a source of significant growth and that the introduction of the Health and Social Care Act 2012—raising the cap on revenues that NHS Foundation Trusts can receive from private patient activity—can be expected only to increase the number of PPUs in coming years. It noted specifically that of the country's 146 Foundation Trusts—each of which has a significant degree of financial autonomy—40 plan to open private patient units.<sup>106</sup> BMI said that PPUs were an excellent opportunity for a new entrant to establish a competitive presence in a local market, particularly in their ability to allow the hospital operator to enter on a scale to meet local demand, making it attractive to form a PPU partnership in an area in which a hospital operator did not already operate a hospital. BMI said that they had a number of other key advantages over new-build facilities. They required a lower capital outlay since they were co-located with an NHS Trust (or an NHS Foundation Trust) hospital and benefited from access to pre-existing infrastructure. This reduced the amount of sunk and fixed costs a private hospital operator had to invest in order to establish a presence in a market. BMI said that PPUs also found it easier to attract consultants who benefited from the convenience of their location, usually on the same site as their NHS base, and to the availability close by of the NHS hospital's acute medical facilities. BMI told us that it had considered the feasibility of taking over

---

<sup>106</sup> Information obtained under the Freedom of Information Act 2000 by Gareth Thomas MP (Lab Harrow West) and reported in *the Guardian* in April 2013 (see [www.theguardian.com/society/2013/apr/06/nhs-hospitals-increase-private-patients?view=mobile](http://www.theguardian.com/society/2013/apr/06/nhs-hospitals-increase-private-patients?view=mobile)).

a PPU on a large number of occasions, overwhelmingly in local areas where it did not already operate a hospital. BMI also said that it had recently been unsuccessful in tendering for a PPU at the University of South Manchester NHS Foundation Trust, which was 12 minutes' drive from its Alexandra hospital.<sup>107</sup>

- 2.196 BMI listed a number of legal issues which it said the CC would need to consider carefully before it adopted the remedy in the form set out in the Remedies Notice:
- (a) whether intervention was compliant with EU procurement rules that applied to the selection of partners by Trusts;
  - (b) whether the remedy would be more effective and proportionate if PPU tenders were brought within the existing merger control regime; and
  - (c) whether it would be advisable to issue a statement to the effect that it considered a PPU outsourcing contract where the Trust agreed to contribute any private revenues that it currently generated to the PPU to constitute an 'enterprise' within section 23 of the Act.

- 2.197 BMI said that the restriction should apply only to the first procurement that an NHS Trust (or Foundation Trust) ran. Where that first procurement was unsuccessful, for example if there were no compliant tenders, the Trust should be permitted to run the tender in an unrestricted way, whereby the incumbent hospital operator would be permitted to bid for the contract. This was on the basis that if the only way to secure the required investment, development of facilities and expansion of services, as well as income stream for the NHS, in a local area was to allow the incumbent to partner the NHS, then it would be perverse for patients to be denied the benefit of such investment.

---

<sup>107</sup> BMI told us that the Trust did not wish to proceed with a local provider (ie BMI) [§§]. In the event, HCA won the contract.

2.198 BMI raised a number of points on the implementation and monitoring of the remedy.

It said that the CC would have to clearly outline which markets it considered to be Single and Duopoly on which the parties could comment and, in the interests of certainty, consider specifying which NHS Trusts/Foundation Trusts it wished to restrict from running full tender processes and which providers it intended to disqualify from which tender processes. It said that there would have to be a process for ongoing assessment and, if necessary, modification of the classification or specification of Single and Duopoly markets to take into account new entry and expansion or hospital closure. It said that this could be done (most likely) by way of self-assessment or (alternatively) by an independent body, but that in any event an independent body would be required for oversight and enforcement and resolution of disputes. BMI suggested Monitor would be the most appropriate body to undertake this role.

2.199 Finally, BMI said that the remedy would have to be subject to a sunset review given the process of change ongoing as a result of the 2012 Act and that it would be appropriate to undertake this review after a period of three years.

2.200 HCA said that a restriction on providers preventing them from entering into partnerships with NHS Trusts to build new PPU capacity and/or improve existing PPU facilities could seriously restrict the ability of Trusts to seek and develop partnerships with appropriate providers with the right operational skills, experience and expertise and the willingness to invest in these projects.<sup>108</sup> It said that this remedy, far from addressing any AECs, would create new and unintended market distortions by limiting the number of providers who would be able to bid for these partnership opportunities.

---

<sup>108</sup> [HCA response to Remedies Notice](#), Section 8.

2.201 HCA said that NHS Trusts were ‘contracting authorities’ within the meaning of EU procurement law and were required to go out to competitive tender when selecting providers to manage and operate their PPUs.<sup>109</sup> It said that the Trusts, as a matter of EU procurement law, were required to select providers on the basis of the most economically advantageous tender. HCA said that EU procurement law prescribed the circumstances in which firms may be excluded from tenders and did not allow NHS Trusts to reject bids on competition grounds and a remedy requiring an outright prohibition might thus conflict with European law.

2.202 HCA said that existing competition legislation provided the appropriate framework for the OFT and in due course the CMA to investigate and decide whether a public/private partnership would restrict competition in a local area, rendering a remedy restricting existing operators from further market growth unnecessary.<sup>110</sup>

2.203 It said that if it was the CC’s case that the competition authorities did not already have sufficient powers under the Act/Competition Act 1998 to review PPU partnerships, they could in principle be provided with the powers to review new PPU transactions. HCA noted that a remedy along those lines would be more likely to represent a more proportionate means than divestiture of addressing the CC’s concerns. It said that if the CC pursued this remedy HCA would engage constructively with the CC to assist in formulating such a remedy and that there were a number of issues on which it would wish to comment in response to the provisional decision on remedies. These included the type of agreements and transactions which were within the scope of the remedy, which regulatory authority was best placed to undertake a review of transactions, the tests which were to be applied and the time

---

<sup>109</sup> [HCA response to Remedies Notice](#), paragraph 8.4.

<sup>110</sup> [HCA response to Remedies Notice](#), paragraph 8.8.

period that this remedy would be in place and the mechanisms for reviewing its effects in the market.

2.204 Spire told us that there was no basis for any remedy whatsoever because the provisional findings did not establish any AEC to the requisite legal standard. However, leaving aside the lack of evidence to support any remedy, the proposed measure would provide private hospital operators that were not active in a given local area with additional opportunities for entry.

2.205 Spire disagreed with our assessment of the likely impact of the lifting of the private patient income cap in our provisional findings.<sup>111</sup> It said that the removal of the private patient cap under the Health and Social Care Act 2012 had led a significant number of NHS trusts to explore opportunities to generate additional private revenues, including through PPUs. It said that PPUs had recently opened or were being developed in [redacted].<sup>112</sup> It cited the examples of the Clatterbridge Clinic in the North-West of England; the Addenbrooke's PPU in Cambridge, which Ramsay had been awarded the contract to operate; the recently announced Royal Derby private patient ward;<sup>113</sup> and the Cornelia Suite at the Poole Hospital.<sup>114</sup>

2.206 It said that, in addition, several NHS Trusts, including Southampton City, Stanmore, Wythenshawe, Wrightington, Barts, Guy's and St Thomas' and St George's were engaged in formal procurement processes for commercial development partners, elements of which were for private hospitals.<sup>115</sup>

---

<sup>111</sup> [Spire response to Remedies Notice](#), Section 5.

<sup>112</sup> [Spire response to Remedies Notice](#), paragraph 5.3.

<sup>113</sup> [redacted]

<sup>114</sup> [redacted]

<sup>115</sup> [Spire response to Remedies Notice](#), paragraph 5.3(e).

- 2.207 Spire said that it expected the trend of NHS facilities seeking to expand their private patient offerings would continue and that there would be significant opportunities for private operators to partner with NHS Trusts to operate PPUs in the future. It said that private patient income in English NHS hospitals rose by 12 per cent in 2012/13 and was forecast to grow by a further 10 per cent in the next 12 months.<sup>116</sup>
- 2.208 Spire said that the remedy would only be effective if it provided clarity and certainty to NHS Trusts and private operators. It said that it was currently unclear which private hospital operators would be eligible to bid to operate a PPU, and therefore how the NHS could run an effective bidding process, because, for example, the CC's analysis did not set out how far away a private operator's hospital would need to be from a proposed PPU in order for a private operator's eligibility to be determined. It said that the adoption of a standard geographic radius, based on the average of the market sizes the CC had identified across the UK, would be a sensible approach. Further, it said that this lack of clarity had already led some NHS Trusts to seek from Spire a guarantee that the proposed remedy would not bar it from operating a PPU as a condition of it participating in the bidding process.<sup>117</sup>
- 2.209 Spire also sought clarification of the circumstances in which an operator might be eligible to operate a PPU. It said that the remedy could be framed to permit an NHS Trust to partner with an incumbent operator where no other operator could be found within a reasonable time period.<sup>118</sup>
- 2.210 Spire said that a number of aspects of the remedy would require careful monitoring, for example whether a private hospital was operating in the same geographic area as the proposed PPU and whether an existing private hospital was a Single or Duopoly

---

<sup>116</sup> [Spire response to Remedies Notice](#), paragraph 5.4.

<sup>117</sup> [Spire response to Remedies Notice](#), paragraph 5.5.

<sup>118</sup> [Spire response to Remedies Notice](#), paragraph 5.11.

hospital. It said that an effective and more practicable approach to the remedy might be to specify that the acquisition of a PPU contract was a relevant merger situation under the Act and therefore subject to merger review.<sup>119</sup> It said that the OFT would be well placed to assess the competitive effects of a transaction such as the acquisition of a PPU contract but it was entirely unclear how the OFT could apply a LOCI assessment or interpret the CC's approach to Single and Duopoly areas.<sup>120</sup>

2.211 Nuffield said that restrictions on incumbents partnering with NHS Trusts would prevent new entrants and incumbents from competing on a level playing field.<sup>121</sup> If the only way an operator could offer tertiary services was to partner with the NHS hospital, because it had ICU facilities for example, then the incumbent would be denied this opportunity. It said that in recent years it had seen more higher-acuity procedures undertaken and that in smaller markets a PPU might offer the only feasible environment in which to deliver these services. Prohibiting a partnership with the local Trust would thus constrain an incumbent's ability to respond to market trends.

2.212 It gave the example of its 'Solus' hospital in Plymouth which it said was a relatively small PMI market. A rival seeking ways of entering this market might choose to partner with the local NHS Trust: it would be able to offer an environment likely to be attractive to local consultants and would be able to offer higher acuity services. The doctors concerned might then choose to undertake all of their work at the PPU. In these circumstances Nuffield might exit, thus reinstating the status quo of just one operator.

---

<sup>119</sup> [Spire response to Remedies Notice](#), paragraph 5.21.

<sup>120</sup> [Spire response to Remedies Notice](#), paragraph 5.22.

<sup>121</sup> [Nuffield response to Remedies Notice](#), paragraph 4.1.

2.213 Nuffield said that it had considered investing in the development of a Trust's PPU which, once complete, would be partially funded by the sale of its existing hospital which could lead to a reduction in local concentration if the original hospital were to be sold to a new entrant.<sup>122</sup>

2.214 It also noted that while the remedy would address an incumbent's ability to expand in the future it would not address local market power that had been acquired previously.<sup>123</sup> In addition, it said that hospital operators would consider partnering with an NHS Trust outside of their current areas of operation and cited HCA's partnership with the Christie Hospital in Manchester as an example of this.<sup>124</sup>

2.215 Ramsay said that there was no legal basis for applying this remedy to it.<sup>125</sup> As it had not been identified as one of the hospital operators with market power in negotiations with PMIs, any adverse effects arising in the areas where Ramsay had hospitals and which the CC had classified as Single or Duopoly areas could only be in the self-pay sector. However, it said that the concept of Single and Duopoly areas had been derived from the CC's local markets analysis based on data relating to insured patient flows. Since, on the basis of the CC's patient survey and Ramsay's own data, self-pay patients travelled further for treatment than did insured patients, the CC had understated the size of the catchment areas of the hospitals concerned and hence the degree of competitive constraint they were exposed to. It said that the hospitals identified by the CC in the provisional findings did not have Single or Duopoly status for self-pay purposes when measured in the correct catchment area.

2.216 Ramsay said that it was part of [REDACTED]. It said that the constraints that would be imposed by Remedy 3 would be significant because it was aiming to have discus-

---

<sup>122</sup> [Nuffield response to Remedies Notice](#), paragraph 4.6.

<sup>123</sup> [Nuffield response to Remedies Notice](#), paragraph 4.2.

<sup>124</sup> [Nuffield response to Remedies Notice](#), paragraph 4.4.

<sup>125</sup> [Ramsay response to Remedies Notice](#), Section 4.



sions regarding PPUs in areas provisionally identified by the CC as Single or Duopoly areas.

2.217 Further, Ramsay said that it was unnecessary and inappropriate to apply this remedy to all Single and Duopoly hospitals. It said this remedy should only be applied in areas where barriers to entry can reasonably be said to exist, such as central London.<sup>126</sup> It said that partnering with the NHS to launch a PPU in London would surmount some of these barriers to entry and that, in particular, it would be easier to attract consultants to a PPU than to a new full service hospital because that PPU would be attached to the consultant's existing place of work (ie the NHS hospital).

2.218 Ramsay also cited issues of practicability.<sup>127</sup> It said that the identification of Single and Duopoly hospitals and the local areas in which they competed was based on a complex analysis using highly sensitive commercial information which would vary over time. Given this, it would be necessary for the CC to keep Single and Duopoly areas under review in order to ensure that the remedy was applied appropriately. Even so, this would introduce uncertainty into the tendering process and it was not clear if and how NHS Trusts would be aware of which hospital groups they would be able to partner with.

2.219 Circle said that this remedy was appropriate but that it would not, on its own, be effective in addressing market power in Single and Duopoly areas.<sup>128</sup> It said that to be effective the CC would have to combine this remedy with a price control. It said that maximum prices in Single and Duopoly areas should be set at 20 per cent above a basket of prices charged in adjoining local markets.

---

<sup>126</sup> [Ramsay response to Remedies Notice](#), paragraph 4.20.

<sup>127</sup> [Ramsay response to Remedies Notice](#), paragraph 4.24.

<sup>128</sup> [Circle response to Remedies Notice](#), page 7.

2.220 The Ulster Independent Clinic<sup>129</sup> said that it did not believe that the remedy was sufficiently clearly drafted to enable hospital operators to determine which hospitals were affected by the remedy and what types of partnerships or other business agreements were covered. It said that it was unclear whether the CC considered it to operate in Single or Duopoly areas. It said that if the CC did so conclude it did not believe that the remedy would be effective unless directed at all private hospitals in Single or Duopoly areas, as serious distortions of competition could otherwise arise.

2.221 It said that customer detriment would be likely to arise in such circumstances where no new entrant appeared and the incumbent private hospital was prevented from partnering with an NHS hospital. It said that this would arise if patients were prevented from benefiting from imaging and ICU facilities which tended to be extremely expensive and could often only be financed by an effective partnership between hospital operators and PPUs. It said that this was particularly so in a small economy such as Northern Ireland where patients may not be able to travel to Great Britain, either because of the cost and time involved or because their condition would not allow them to do so.

## *Assessment*

### *Relationship to merger control rules*

2.222 We first considered the extent to which the proposed Remedy 3 was necessary in order to address the AECs that we had provisionally found since it was put to us that existing merger control provisions were adequate to meet our concerns.

2.223 We concluded that in circumstances where the award of a PPU contract to a private hospital operator constituted a merger situation falling within the jurisdiction of the competition authorities, competition concerns could be adequately addressed under

---

<sup>129</sup> [Ulster Independent Clinic response to provisional findings and Remedies Notice](#), 5.2 ff.

existing merger control regimes. However, we noted that recent arrangements were structured in such a way that they did not constitute a merger situation under the Act.<sup>130</sup>

2.224 In the case of the arrangement between HCA and the Guy's and St Thomas' foundation trust (GSTFT) the agreement explains that 'GSTFT carried out a competitive tender to select a healthcare provider to develop a dedicated private patients unit within the Cancer Treatment Centre from which the healthcare provider will provide cancer treatment and other services to private patients'.<sup>131</sup> The agreement, however, was effected through the granting to HCA of a lease to part of the Borough Wing with the granting by HCA back to GSTFT of an underlease on part of the property. The OFT decided that this arrangement did not constitute a merger situation under the Act.

2.225 We considered BMI's suggestion (paragraph 2.196) that the CC/CMA should, in effect, deem such arrangements to fall within merger control, whether or not they created a merger situation for the purposes of the Act. We concluded that we did not have the powers to do so under sections 159 or 161 of the Act, but that our powers did enable us to frame a different but appropriate remedy which would address our concerns and have a similar effect.

2.226 We concluded that it would be appropriate for us to adopt a remedy to address this aspect of the AECs as the merger regime in Part 3 of the Act would not, in itself, fully address our concerns because arrangements may be structured in such a way that they do not create a relevant merger situation.

---

<sup>130</sup> Section 79(3) of [the Health and Social Care Act 2012](#) may indicate Parliament's intention to apply merger control to Trusts, but does not appear to extend as far as the arrangements described here.

<sup>131</sup> Agreement dated 8 August 2012, Background (B).

### *Relationship to EU procurement rules*

- 2.227 We next considered the relationship of this remedy to EU procurement rules including the points raised in response to the consultation and in particular whether these rules would limit its effectiveness.
- 2.228 HCA had suggested that this remedy, if it took the form of an outright prohibition rather than a case-by-case review, might fall foul of EU procurement rules which would require NHS Trusts to select providers on the basis of the most economically advantageous tender.<sup>132</sup> We therefore considered whether EU procurement law would affect the design of the remedy, for example whether it would, unless modified, prevent us from prohibiting certain private hospital operators from participating in tenders for PPU contracts.
- 2.229 Our view was that EU procurement rules are intended to ensure that public authorities respect the free movement of goods and services, and enter into competitive tenders, leading to best value for money, but that they could not be used to override competition law or merger control, and that NHS trusts would not be required by EU procurement law to make a contract award which gave rise to an AEC (or SLC). Further, as we were now proposing a case-by-case evaluation of PPU arrangements HCA's specific point relating to outright prohibition no longer applied. We therefore concluded that EU procurement law would not prevent this remedy from working in the way that we intend it to.

### *Implementation*

- 2.230 We next considered how the remedy should be implemented and whether, for example, it would be appropriate to make a recommendation to the Government to amend the Act so as to encompass the kind of arrangements we are discussing here.

---

<sup>132</sup> [HCA response to Remedies Notice](#), paragraph 8.4.

2.231 We concluded that it would be preferable to adopt a remedy directed specifically at PPU arrangements which were structured in such a way that they did not constitute a merger. We then considered how the remedy could be specified in order to achieve this.

*Design considerations and effectiveness*

- *Applicability*

2.232 In our Remedies Notice we proposed an outright prohibition on private hospital operators facing weak competitive constraints, in particular in Single or Duopoly areas, operating PPUs on behalf of the local NHS Trust. We considered whether this approach was still appropriate in view of the submissions that we received in response to our Remedies Notice.

2.233 It was put to us that an outright prohibition in the areas where we had identified competition concerns could be inappropriate on two grounds. First because competitive conditions in those areas might have changed since the publication of our report and second, even if they had not, there could be particular circumstances which made it inappropriate to prohibit a proposed arrangement between an NHS Trust and a private hospital operator.

2.234 We were told that as the competitive conditions in local areas in which individual private hospitals compete can vary over time, for example following entry or expansion, it would be necessary for the CC to adopt a process to keep under review the local areas of all the Single and Duopoly hospitals in order to ensure that the remedy was applied appropriately.<sup>133</sup>

---

<sup>133</sup> [Ramsay response to Remedies Notice](#), paragraph 4.24(b).

2.235 We acknowledged these arguments and agreed that they raised issues of practicability and cost, particularly in the event that our local area analysis had to be continuously updated. We accepted that any list of areas subject to a remedy of this nature that we published at the conclusion of our investigation could become out of date, perhaps relatively quickly, that what was initially a competitive local area might become uncompetitive, and vice versa.

2.236 Further, we reasoned that even in areas where competition concerns persisted or had arisen there might be particular circumstances which would render prohibition inappropriate. For example, and as we discuss later, it might be appropriate to permit a private hospital operator facing weak competitive constraints to manage a PPU if there were no other contender.

2.237 We concluded that rather than adopting an outright prohibition and specifying areas or types of areas and parties which would be subject to it, as we had proposed in our Remedies Notice, it would be preferable for proposed transactions to be evaluated on a case-by-case basis on their merits wherever they arose. The remedy as specified here, therefore, would be applicable to the whole of the UK rather than limited to the areas where we identified competition concerns in our provisional findings. It would thus apply to arrangements in any areas where existing private hospital operators faced weak competitive constraints. In the rest of this section we discuss how the remedy as thus envisaged would work. We first consider the basis on which proposed arrangements should be assessed and then the appropriate body to undertake the evaluation.

- *The basis for evaluation*

- 2.238 The OFT suggested that a 'bright line'<sup>134</sup> competition test, such as that adopted in groceries and set out in Schedule 4 of the Controlled Land Order,<sup>135</sup> would be appropriate. The OFT said that the groceries competition test had worked well, had enabled rapid assessments and had not proved onerous in terms of costs.
- 2.239 The OFT suggested that such a test in this case could comprise different stages.
- 2.240 For example, a first stage could comprise a fascia count of private hospital operators with hospitals within the catchment area of (or isochrone drawn around) the NHS hospital inviting tenders to manage a PPU. In the event that insufficient competitive fascias were present a second test or filter could be applied, for example a fascia count of private hospital operators within the catchment area(s) of (or isochrones(s) drawn around) any of the hospitals of the private hospital operator considering operating the PPU and located within the NHS hospital catchment area (or isochrone).
- 2.241 If this indicated competition concerns then a share of supply test could be applied as a third stage, as in the case of the groceries competition test, to ascertain the bidder's current share of private healthcare revenue in the local area and the likely effect of it operating the PPU. In this case, for example, the proposed operator might, on the basis of fascia count, appear to face weak competitive constraints but in fact have a low share of supply compared with other operators in an area.
- 2.242 We recognized that such a test would have the merit of being fairly simple to operate and monitor. However we noted that, having failed this or any other 'bright line test', the outcome would be a prohibition of the proposed PPU arrangements based upon

---

<sup>134</sup> A straightforward and easy to administer test that would provide unambiguous and consistent results.

<sup>135</sup> Available at: [www.competition-commission.org.uk/assets/competitioncommission/docs/2011/inquirydocs/groceries\\_land\\_order.pdf](http://www.competition-commission.org.uk/assets/competitioncommission/docs/2011/inquirydocs/groceries_land_order.pdf).

the criteria that formed the basis of the test and there would be no ability to take any other relevant criteria into account unless express provision was made for that. A simple test such as a fascia count might therefore fail to capture important characteristics of the local market.

2.243 Such a test would also, for example, assess local competitive constraints on private hospital operators differently from the analysis used in our provisional findings and the results of applying could therefore be inconsistent with our findings. A first stage test based on fascia counts and isochrones could, for example, identify competition concerns outside of London but would not do so in central London where we found that drive times are not as important a factor in hospital choice as outside London and that the range of services offered by individual private hospitals can differ significantly. A simple fascia count in central London would not reveal the cause for competition concerns found by our analysis.

2.244 By contrast we noted that a competition test equivalent to that employed under the existing merger regime (that is, whether the relevant merger situation is expected to result in a substantial lessening of competition in any market or markets in the UK—the SLC test)<sup>136</sup> while less simple than any bright line test, would have the advantage of enabling all relevant circumstances to be taken into account when making a competitive assessment.

2.245 A competition test would assess the extent to which the proposed arrangements for the management of a PPU by a private hospital operator would raise that operator's share in the relevant local area and how this would compare with the counterfactual, that the operator concerned was prevented from operating the PPU. The assessment would take account of actual hospital catchment areas, rather than assuming

---

<sup>136</sup> Section 36 of the Act.



standard drive times, and would differentiate between hospitals on the basis of the nature and range of services that they could offer, for example the level of intensive care that they could provide.

2.246 We noted that there were other advantages to applying a competition test that was the same or similar to the SLC test. First, the SLC is an established test which is appropriate to assessing the effects of an arrangement that meets the criteria of a relevant merger situation. As such it would be suitable for assessing the effects of a proposed PPU arrangement. Secondly, it is a test for which there is an existing competition authority with experience of applying the test (at present, the OFT/CC and in future the CMA). Thirdly there is published guidance available as well as reports of earlier decisions that may be informative about how the relevant body will approach the assessment. Fourthly, as we have noted, some PPU arrangements may be subject to review under the existing merger controls. If a test applicable to any such arrangements that do not fall within such controls is in the same or similar terms there is added advantage of similar treatment.

2.247 We therefore concluded that the competition test that should be applied should be the equivalent of the SLC test. We also decided that, as under the Act, RCBs (as defined by section 134(8) of the Act) should be able to be taken into account before deciding whether the proposal should be prohibited or not. In some cases it may be necessary to obtain appropriate undertakings from the relevant private hospital operator as a condition of giving clearance (see, for example, paragraph 2.263 below).

2.248 While the competition test would resemble the SLC test, there would be differences in its application. For example, the decision would be taken in all cases without a stage 2 reference being made, and so the provisions in the merger regime relating to

circumstances in which a second-stage reference is not made would not apply. There would therefore be a theoretical possibility of different outcomes depending upon whether the competition test or the merger control provisions applied. However, we considered that the likelihood of different outcomes arising is low. In any event, our aim is to design an appropriate test to make a relevant assessment.

2.249 As we have noted, the disadvantage of such a competition assessment, is that it creates less certainty than a bright line test. We note too that such a test may be more costly to operate. We considered therefore whether it should apply to all proposed PPU arrangements or some only and, if so, what the criteria should be for exemption.

2.250 We considered two ways in which these factors could be addressed. We considered whether it would be appropriate to include in the remedy a 'safe harbour' provision whereby a transaction could be relieved of further scrutiny if it could be shown that it would not give rise to an increase in the private hospital operator's share of supply in the relevant area to more than 25 per cent which is the equivalent threshold in section 23 of the Act. We also considered whether transactions below a certain value could be deemed to be de minimis and, if so, where this level might be set and whether the current threshold for tenders to be advertised under EU procurement rules would be appropriate.

2.251 We would welcome views from interested parties in particular on both these issues.

- *Monitoring and enforcement*
  - The appropriate body

2.252 We next considered which regulatory authority would be best qualified to undertake the competition test, or whether it would be necessary to create a new body to do so.

We reasoned that since the competition test that we have provisionally decided to adopt is broadly equivalent to the SLC test applied by the OFT/CMA in merger evaluations and as the OFT/CMA would continue to assess PPU arrangements which constituted mergers, it would be the most appropriate body to undertake the competition test we are proposing as the basis for Remedy 3. However, given its sector expertise and the concurrent powers that it has with the OFT to enforce the provisions of the Competition Act and make references under the Act we also considered whether Monitor would be suitable for this role.

2.253 We noted that Monitor has no regulatory responsibilities outside of England.

Although, currently, health policy in Scotland, Wales and Northern Ireland makes it unlikely that PPUs will be launched there, we could not be sure that this would always be the case. We therefore concluded that Monitor would not be the appropriate body to make the assessment since it could not do so across the whole of the UK.

- Pre-notification

2.254 We considered whether it was necessary or appropriate for private hospital operators or NHS foundation trusts contemplating arrangements for the management of a PPU that would be affected by this remedy to notify the OFT/CMA prior to entering into a binding agreement. We noted that the CC had required pre-notification in the context of the 'competition test' arising from its investigation of the groceries market which has some features in common with Remedy 3.

2.255 We considered whether pre-notification would be appropriate on the ground that the OFT/CMA might not be aware of proposed arrangements.

2.256 We were told that, subject to the value of the contract, a trust would be obliged under EU Procurement Rules to advertise its invitation to tender in the Official Journal of the EU, so we considered that it would be relatively simple for the OFT/CMA to maintain awareness of proposals to involve private hospital operators in the management of PPUs. Further, we thought that Monitor might draw the OFT/CMA's attention to such proposals, since it would be aware of them as a result of its reviews of the forward plans of NHS foundation trusts.

2.257 On the other hand, we reasoned that the OFT/CMA had many duties to perform and it was possible that, without notification, a proposal might escape its attention. In addition we thought that the burden on parties of pre-notifying the OFT/CMA was likely to be minimal. A pre-notification requirement would also ensure that all PPU arrangements to which this remedy is intended to apply would be notified.

2.258 We concluded that, on balance, pre-notification of all PPU arrangements was appropriate. We thought that the low cost to parties of pre-notification was outweighed by the risk that a tender might be missed. We considered that this pre-notification requirement should apply to all PPU arrangements, including those that fell for review under the merger control regime. We thought that this would remove the risk that the parties concerned might fail to notify the OFT/CMA of an arrangement which was covered by the remedy but which the parties considered to be a merger.

- *Conclusions on effectiveness*

2.259 This is a market opening measure intended to introduce greater rivalry in areas where existing private hospital operators face inadequate competitive constraints. The remedy will only apply in areas where a NHS Trust proposes to enter into arrangements with a private hospital operator in relation to a PPU. This remedy in

isolation will therefore not address the AECs comprehensively but should be seen in the context of the package of remedies that we have provisionally decided to adopt.

2.260 We next considered whether the remedy was reasonable and proportionate.

### *Proportionality*

2.261 We considered whether this remedy would impose costs on parties and how onerous these were likely to be. We considered that parties would incur the costs of notifying proposed PPU arrangements to the OFT/CMA, but that, as they are also preparing a tender to the relevant NHS Trust, the additional costs of notifying the OFT/CMA appeared not to be onerous. In addition, if the OFT/CMA decided that the proposed arrangements had to be blocked, the relevant party could at that stage withdraw from the tender process. We thought that the costs to the OFT/CMA of monitoring the remedy would be low as we have provisionally decided to require pre-notification of all proposed arrangements for outsourcing the management of PPUs to private hospital operators. Thus the degree of monitoring that would need to be carried out would be low.

2.262 We considered that costs to customers could potentially arise from the application of the remedy. For example, if the OFT/CMA blocked a proposed arrangement and as a result the proposed PPU would be unable to proceed because there were no alternative candidates to operate it, then consumers in the local area could suffer detriment.

2.263 However, we took into account that we have provisionally decided the remedy should be applied on a case-by-case basis, so that in such circumstances the OFT/CMA

would be able to take account of all relevant factors as part of its evaluation and would be able to clear the proposed arrangements.<sup>137</sup>

### *Conclusions on proportionality*

2.264 We provisionally decided that the remedy would be reasonable and proportionate.

### *Conclusions on Remedy 3*

2.265 We have provisionally decided, for the reasons set out here, that the remedy which would require arrangements between PPUS and private hospital operators for the operation of a PPU to be notified to the OFT/CMA for review. The OFT/CMA would prohibit those arrangements found by the OFT/CMA to not meet the competition test described above. We consider that such a remedy is likely to be effective in addressing the AECs and would be proportionate.

---

<sup>137</sup> In such circumstances we would expect that it would be necessary for the OFT/CMA, in addition, to obtain appropriate undertakings from the hospital operator as a condition of clearance being given.

## **Remedy 4: Clinician incentives**

### *Introduction*

2.266 In our provisional findings,<sup>138</sup> we found that one way in which private hospitals compete for referrals is by adopting schemes which encourage consultants to refer patients to, or treat patients at, their facilities and that these schemes were widespread. We found that such schemes were much more commonly directed at consultants than at GPs.

2.267 We provisionally concluded that incentive schemes do affect consultant behaviour, by affecting their referral decisions and by possibly leading to excessive diagnostic tests or consultations.<sup>139</sup> We also concluded that equity ownership by consultants of private health facilities gives rise to harmful effects on competition, except where such ownership results in a reduction in barriers to entry that is likely to be at least as beneficial to competition as any distortion is harmful.

2.268 In our Remedies Notice, we proposed that consideration be given to preventing hospital operators from offering any incentives to consultants, whether in cash or kind, which are intended to or have the effect of encouraging doctors to refer patients to, or treat them at, its hospitals.

2.269 In this paper, we:

- (a) summarize our provisional findings on clinician incentives and the remedies we considered in our Remedies Notice;
- (b) set out the responses to the Remedies Notice that we have received from the parties;

---

<sup>138</sup> [Provisional findings](#), Section 8.116.

<sup>139</sup> [Provisional findings](#), Sections 8.133 & 8.134.

- (c) describe what further research we have done, including into the regulation of clinician incentives in the USA, Canada and Australia;<sup>140</sup>
- (d) summarize the current regulatory environment in the UK; and
- (e) set out our provisional decision on remedies to address the AEC arising from clinician incentives.

### *Provisional findings on clinician incentives*

2.270 One of the ways that private hospitals attract business is by encouraging doctors to treat private patients at their facilities. As most patients are referred to consultants by GPs, hospitals may also try to encourage GPs to refer patients to consultants who use their facilities though incentive schemes aimed at GPs were rare.

2.271 Private hospitals encourage consultants to use their facilities in a variety of ways. They promote themselves to consultants (and GPs) in communications or at events, where they describe the quality of their staff and the facilities and equipment that they have invested in. They commonly offer access to resources to make using their facilities more convenient for a clinician, for example making consulting rooms or secretarial services available. They may also operate schemes which provide financial benefits to consultants using their facilities.

2.272 In our provisional findings, we examined whether any or all of these arrangements might distort competition.

2.273 We found that schemes to attract business by encouraging consultants to refer patients to, or treat patients at, private hospital operators' facilities were widespread.

---

<sup>140</sup> The main body of this research is in Appendix 2.7.



- 2.274 We found that such schemes were not confined to particular areas of the country or hospital types: some independent private hospitals as well as most of the main private hospital groups had, to a greater or lesser extent, adopted them. However, there was some evidence that schemes which directly rewarded consultants for referrals were most likely to be adopted during periods, in geographic areas and in medical specialisms where hospital competition for consultants was strongest.
- 2.275 Private hospital operators, in their submissions on this issue, generally argued that in some parts of the country the practice of offering incentives to consultants had become commonplace since it was necessary to do so in order to attract key consultants and that competition for consultants was intense. Some said that they would welcome clarification from us on the merits and de-merits of various types of scheme.
- 2.276 The insurers generally condemned incentive schemes for doctors, expressing concerns about both medical and competitive effects. Bupa and AXA PPP both made extensive submissions on the subject, including evidence which they said demonstrated that harmful effects were occurring.
- 2.277 Our AIS raised the question as to whether incentive schemes gave rise to barriers to entry and some of the responses received (most notably that from HCA) focused on that issue. HCA argued that there was no concrete evidence that consultant incentives created any foreclosure effects in the market. HCA also said that Circle's consultant incentive model had been important to its entry. Spire said that an outright ban on consultant incentives might have unintended consequences.

- 2.278 Patients rely to a large extent on the advice of GPs and consultants. In general, any arrangement by which the economic benefit to the adviser varies according to the advice given has the potential to distort competition between hospitals for referrals.
- 2.279 We were concerned that consultant incentives might induce consultants to refer patients to a hospital that they would not have chosen on grounds of either quality or of price and that they might lead to overtreatment or unnecessary diagnostic tests.
- 2.280 We examined the evidence and provisionally concluded that incentive schemes did affect consultant behaviour. We said we believed that an intention of these schemes was to affect consultants' referral decisions and that the schemes had that effect. We also found that, on balance, the evidence indicated that incentive schemes were likely to lead to excessive diagnostic tests or consultations. These effects distort the market.
- 2.281 We therefore provisionally concluded that the existence of incentive schemes operated by private hospital operators which encourage patient referrals for treatment at their facilities gave rise to an AEC. We also concluded that equity ownership by consultants of private health facilities gave rise to harmful effects on competition, except where such ownership results in a reduction in barriers to entry that is likely to be at least as beneficial to competition as any distortion is harmful.

### *Our proposed remedy*

- 2.282 In our Remedies Notice,<sup>141</sup> we proposed that consideration be given to preventing hospital operators<sup>142</sup> from offering to consultants any incentives, whether in cash or kind, which were intended to or had the effect of encouraging consultants to refer

---

<sup>141</sup> Remedy number 4.

<sup>142</sup> Hospital operators, in the context of this remedy, includes PPU's (whether run by a private hospital operator or an NHS Trust) as well as private hospitals.

patients to, or treat them at, its hospitals. The proposed remedy included equity participation schemes as well as short-term reward schemes, except where such equity participation resulted in a reduction in barriers to entry that was likely to be at least as beneficial to competition as any distortion was harmful.

2.283 The proposed remedy would permit private hospitals to make certain facilities, for example consulting rooms, available but only if they could not be deemed to constitute an incentive to consultants to bring work to the hospital operator, for example if it could be demonstrated that they were being charged for at a fair market price.

2.284 In our Remedies Notice we said that, for the avoidance of any doubt, the CC would interpret this as prohibiting such arrangements even if they included caveats obliging the consultant to comply with GMC guidelines or stated that the agreement imposed on the doctor no obligations to refer patients to or treat them at the hospital operator's facilities.

*What parties told us*

- *PMIs*
- *Bupa*

2.285 Bupa said that all incentive arrangements between consultants and private hospital operators should be removed, whether they were short term (eg referral fees) or long term (eg equity stakes).<sup>143</sup> It said that a similar prohibition should apply to incentives paid to consultants by other healthcare providers, such as laboratories or medical device providers, where they affected referral patterns.

---

<sup>143</sup> Bupa said that a very low de minimis threshold exemption—an indicative level might be £500 per doctor a year—could be acceptable to cover, for example social events, promotional stationary, or facilities for training events. Such payments may not sufficiently affect consultant behaviour (in particular, referral patterns) to warrant prohibition.

2.286 Bupa said it accepted that there was a case for exempting from any prohibition the provision of certain services and/or facilities to consultants (eg consulting rooms, secretarial services) where these were provided at full market rates,<sup>144</sup> provided that there was full disclosure of these arrangements, for example on the hospital's website, and such exemptions were strictly controlled such that they did not of themselves have a tying effect. For example, if the duration of any contract under which facilities were offered was particularly long term (eg longer than one year), with no option for the doctor to terminate early without penalty, then in Bupa's view the very duration of the contract would have a tying effect between the hospital operator supplying the facility and the consultants benefiting from it.

2.287 If the CC were minded to exempt particular types of incentive arrangement between consultants and a hospital which was a new entrant, then Bupa's view was that both the hospital operator and the consultants should be obliged publicly to disclose the details of these arrangements. Bupa said that this transparency would allow any non-exempted arrangements to be reported by other consultants, hospitals, patients or insurers and, if necessary, investigated and sanctioned by the GMC. It said, however, that it did not believe that it was practicable to identify clearly those equity participation schemes that were likely to be at least as beneficial to competition as any distortion was harmful. Consequently, an attempt to draw such a line between different schemes was likely to create inconsistencies and complexity, at the expense of clarity.<sup>145</sup>

---

<sup>144</sup> Bupa noted the definition of 'fair market value' in the USA under the Stark Acts, and said that it saw some merit in the CC considering a similar approach.

<sup>145</sup> Bupa said that its concerns were restricted to equity participation schemes in hospitals providing inpatient care and it did not take issue (in the context of its response to the CC's proposed remedies) with consultants participating in the equity of consultant clinics.

2.288 Bupa said that there should be penalties for hospital operators, hospitals and consultants who had entered into incentive arrangements in breach of any CC remedy relating to consultant incentive arrangements.<sup>146</sup>

○ *AXA PPP*

2.289 AXA PPP told us that it agreed with the CC that incentive schemes influenced behaviour and gave rise to an AEC. It also agreed that hospital operators should be prevented from offering to doctors any incentives in cash or in kind, direct or indirect. It considered that, similarly, doctors should be prevented from asking for, or accepting, any such incentives. It did not agree that incentives should be allowed where they might reduce a barrier to entry and thought that all incentives of any kind, including equity ownership, should be banned. It said that some level of carve out might be required where ownership was outside the recipients' control, such as collective investments, but that any such exemptions should be tightly drawn.

2.290 AXA PPP thought that there was a risk that any ban on incentives might be partial or imperfect, and capable of circumvention by an inventive hospital operator. It thought that the CC should go further, and extend its proposed remedy to deal with excessive profit margins in specific areas, ie those such as tests and scans that were easily influenced by incentives. For a prescribed list of tests, scans and drugs to be defined,<sup>147</sup> it said that PMIs should have the right to make their own procurement arrangements from wholesalers of these products and services. Hospitals and clinics would then be required either to charge at the same rate as that secured by the PMI or to make use of the separate wholesale arrangement made by the PMI. It said that

---

<sup>146</sup> Bupa noted that the Physician Payments Sunshine Act and the Stark Acts (both in the USA) provided for organizations and individuals to be fined for failure to disclose the details of incentive arrangements or entering into prohibited incentive arrangements.

<sup>147</sup> AXA PPP said that the Stark Acts in the USA provided a good starting point for drawing up such a list but that cardiac testing and the supply of prostheses should be added. However, by setting out precisely what cannot be done, it said the Stark Acts also set out where incentives could be applied. In its view, the ban on incentives should be without exception and the UK needed a robust enforcement framework akin to that in the USA.

this would significantly increase the level of price competition, to the benefit of the consumer.<sup>148</sup>

- *Aviva*

- 2.291 Aviva told us that no one should be offering incentives, in cash or in kind, to encourage referral of patients to or for treatment at a hospital. It said this should include incentives offered to providers of primary care services as well as consultants. Aviva said it also believed that consultants should be obliged to inform patients of their options in relation to hospital facilities and, where appropriate, tell the patient why they were proposing a particular hospital.
- 2.292 It said that a de minimis exemption, eg for a Christmas present, could be acceptable but any such gifts should be recorded somewhere.
- 2.293 Aviva said that it did not support an absolute prohibition on consultants owning a financial interest in a hospital or a clinic, and that equity participation by consultants could, in limited circumstances, bring benefits. Banning all equity schemes could limit opportunities for innovation and hamper the development of new services or new propositions of the sort that Aviva would like to see, though it thought that the pro-competitive benefit of investments in new experimental treatments, for example, should have to be demonstrated by doctors to PMIs rather than to some third party. Aviva said that it found it difficult to draw the line on which equity schemes should be permitted but believed that gifted equity stakes (as against equity stakes purchased at fair market value for cash) should be prohibited.
- 2.294 It said that, in addition to the duty to disclose any payments which is imposed on doctors by the GMC, private healthcare providers should face a duty to record and

---

<sup>148</sup> This is considered in more detail in paragraphs 3.96 & 3.97 of the provisional decision on remedies.

disclose all direct payments made to consultants. Any provider found to have made a payment in breach of this obligation should be liable to a financial penalty.

- *PruHealth*

2.295 PruHealth said that it had no objection to consultants investing their own money in healthcare facilities, provided that it was restricted to an equity shareholding of less than 10 per cent. It said that equity shareholding was generally only an issue when its size was sufficient to influence adverse behaviours. In the case of a publicly listed company with a transparent dividend return, one consultant's over-servicing behaviour, with less than 10 per cent shareholding, would have a minimal effect on the company's dividend return to its shareholders. There was a degree of complexity with private or charitable institutions, and dividend schemes based on phantom shares could be formulated, but transparency was essential.

2.296 PruHealth thought that perverse incentives included:

- (a) cash rewards based on the number of admissions or level of cost generated;
- (b) cash incentives to join a particular facility or hospital;
- (c) cash or other incentives to prescribe or utilize specific drugs, appliances or prosthesis; and
- (d) subsidized or free consulting rooms and/or administration services.

It said that these perverse incentives should be banned for all health professionals, including GPs as well as consultants, and the remedy should apply to laboratories, pharmaceutical companies, suppliers of medical consumables and imaging service providers without limit. The GMC should be made responsible for monitoring financial incentives to doctors, and HMRC had a role in ensuring that any declared income from private practice was justified against an expense statement. It said that no private consultant should be generating private income without incurring or explaining their administration and rental expenses.

2.297 PruHealth said that improving diagnostic and procedure coding would enable cases of over-servicing or inappropriate utilization of treatments/investigations to be readily identified by both the hospital and the PMI. It favoured anti-kickback legislation and public declaration in a register of all gifts or benefits in kind received over a certain financial value.

- *Hospital operators*

- *BMI*

2.298 BMI told us that it did not consider there was a compelling competition case to prohibit consultant incentive schemes but for various reasons considered them undesirable [§]. It said that it saw no reason why a prohibition on entering into new agreements of this nature should not be immediately effective but a period of six months should be allowed to unwind existing agreements.

2.299 BMI said that the provision of certain facilities to assist consultants with their practices, for example consulting rooms, should not be prohibited if it could be shown that they were being charged at a fair market price though said it would welcome guidance from the CC on what constituted a market price. It said that it would also welcome a de minimis provision to provide certainty for hospital operators that small benefits, such as printing letterheads and the provision of free consulting space for newly appointed consultants for a limited period, would not constitute a breach of the prohibition. It thought that a threshold of £2,000 would be appropriate.

2.300 Regarding equity investment or joint venturing by consultants, BMI said that in itself, without any commitment for referrals, it was not generally harmful to competition and at the very least would require a case-by-case assessment. It said that equity participation schemes which did not require a consultant to refer a patient to any particular facility and where they were free to make this decision based on their own



clinical judgement should properly be considered joint ventures and not incentive schemes at all. It said, however, that there was no basis whatsoever for equity participation schemes or joint ventures to contain any referral commitments, that this prohibition must be absolute and that referral incentives dressed up as equity clearly needed to be prohibited. It said that prohibition of referral commitments between consultants and hospitals was front and centre of this remedy.

- *HCA*

2.301 HCA told us that it was important that any remedy which restricted ‘incentives’ was clear in scope, created legal certainty and applied non-discriminately to all healthcare providers and to PMIs.<sup>149</sup>

2.302 It said that it saw a case for a prohibition of schemes which provided benefits which were directly linked to patient referrals. It advocated restricting:

- (a) minimum referral commitments expressed in terms of volume or value of referrals;
- (b) payments or other benefits tied directly or indirectly to the volume or value of referrals;
- (c) ‘lock-in’ provisions pursuant to which a consultant must commit to bring a minimum proportion of his/her practice to the hospital (such as Circle’s scheme); and
- (d) arrangements having equivalent effect, for example exclusivity requirements in practising privileges which prevented or restricted consultants from practising in rival facilities.

2.303 HCA agreed that any arrangement should not be deemed to be an ‘incentive’ if it represented an arm’s length, commercial relationship under which the consultant was

---

<sup>149</sup> [HCA response to Remedies Notice](#), paragraphs 9.22 & 9.28.

being charged a fair market price, such as its own arrangements for letting consulting rooms, which were at fair market value. It did, however, support the provision of consulting rooms on a rent-free basis to new consultants for the first six months to help them establish a practice, though such arrangements should not be tied to any referral requirements. It said that it also supported a de minimis threshold which would allow very limited subsidies to assist with consultant set-up costs.

2.304 It told us that equity schemes played a valuable role in encouraging consultants to innovate and create new services. HCA said that it did not agree with the binary distinction in the provisional findings between equity schemes applying to new hospitals and equity schemes applying to other facilities such as individual pieces of diagnostic equipment. It said that the pro-competitive impact of equity schemes which unlocked new investment and encouraged the delivery of new products and clinical services applied to new clinical units and facilities by an existing hospital operator which would not come to fruition without consultant engagement.<sup>150</sup> Equity participation encouraged consultants to be involved in the strategic direction of the new venture and devote their time to developing new services.

2.305 HCA thought that any incentives to conduct unnecessary diagnostic tests or consultations could be overcome by peer review procedures ensuring effective clinical governance.<sup>151</sup> It suggested prohibiting any express requirement to treat patients at a particular facility, and supported increased transparency of consultant equity participation (eg prominent notices on site or in any documentation issued by the consultant to the patient).

---

<sup>150</sup> HCA cited examples, including the establishment of a CyberKnife treatment facility at the Harley Street Clinic.

<sup>151</sup> All clinical referrals to the CyberKnife centre, for example, were screened by a medical director and a clinical research fellow, and then by a multidisciplinary team, the majority of whom were not members of the CyberKnife JV, based on clinical criteria.

2.306 HCA said that the scale of payments typically made to consultants under equity schemes was unlikely to create a significant incentive effect. The median consultant equity investment in its joint ventures was around £[£] and the annual payment to the consultant was £[£], which it said was not enough to create an incentive to carry out unnecessary tests.

2.307 It said that any remedy should also extend to NHS incentives or restrictions which sought to tie NHS consultants to the NHS Trust's PPU. It also said that similar remedies should apply to PMI incentives to consultants which distorted referral patterns and influenced consultant behaviour, such as Bupa's Premier Consultant Partnership Scheme. It said that a remedy would not be fair or proportionate if it applied to hospital operators but not the PMIs.

- *Spire*

2.308 Spire agreed with the CC that direct incentives in the form of payment for referral should not be permitted though it considered that we had overstated the scope and potential impact of incentive arrangements. Spire said that any remedy must be proportionate to the (limited) extent of the concerns raised. It said in particular that it agreed with the CC that ethical and regulatory constraints which apply to consultants could be expected to offset to a substantial extent any economic incentive for a consultant to offer advice that was not in the patient's best interest.

2.309 It said that certain arrangements between hospitals and consultants can have significant pro-competitive effects but that the CC's remedies risked preventing certain arrangements that benefited patients by bringing new facilities, services and consultants to the market or encouraging the use of emerging technology that may ultimately result in more cost-effective healthcare. It said that, as the CC had noted, equity participation was an effective means of incentivizing consultants to commit to

working in a new hospital, thereby facilitating the entry of new facilities, and especially of new and innovative service offerings with neither a hospital operator nor a consultant would be able to bring to market alone. In many cases, the consultant might seek to partner with a hospital group which had the financial resources, management and marketing skills to bring the new service to market (but lacked the specialty expertise to launch the service itself). It said that a risk-sharing approach, in a hospital operator co-invested with a consultant, could help launch novel services. Absent such co-investment, new services—which expanded patient choice and drove innovation—might not come to market. Spire said that permissible co-investment should be limited to the investment of cash or tangible assets by the consultant and the distribution of profit or revenue created by the investment should be proportionate to the consultant's investment.

2.310 It said that the regime should permit:

- (a) hospitals to provide free or discounted consulting rooms and administrative support to new consultants in their first 12 months of private practice, which would otherwise be costly;
- (b) the co-development of new facilities or services that fell short of full-scale hospitals; and
- (c) day-to-day arrangements relating to the provision of treatment to patients, most of which were either of minimal value and/or were provided at market rate (such as complimentary coffee or use of parking facilities and training and development).

Spire also noted that implementation of an unduly expansive prohibition would be extremely bureaucratic and time-consuming to monitor but would have no effect on consultants' decision-making and/or competition between hospitals. It said that the kind of broad prohibition envisaged by the CC in its Remedies Notice could have perverse results.

2.311 Spire recommended that the remedies that the CC envisaged should be overseen by Monitor which was a credible, independent agency with considerable expertise and experience in overseeing competition in the healthcare sector. It said that the use of an existing body would help to minimize enforcement costs. It envisaged that the costs associated with enforcement would not be excessive and might be limited to one additional full-time-equivalent employee and that the costs involved could be met by the firms falling under its remit.

2.312 Spire said that it did not consider the introduction of a Stark Law approach to the UK market to be appropriate. It was not a straightforward and readily implementable regime and in the USA had become an extremely complex set of rules and exceptions.

2.313 Spire also said that the immediate termination of existing arrangements between hospitals and consultants could lead to the termination of certain services, resulting in disruption for patients. It said that any existing arrangements should be 'grandfathered' and purely contractual arrangements should be allowed to continue until the end of their current contract term. It said that, at the very least, there should be an extended period for an orderly wind down to avoid the risk of service disruption to patients.

- *Nuffield*

2.314 Nuffield told us that it agreed with the need for a complete ban on consultant incentives, whether in cash or in kind. However, it said that the CC would need to be careful in considering the implications of loopholes offered to new entrants that used consultant incentivization to lower barriers to entry. Nuffield said that it did not see a need for new entrants to provide their consultants with an incentivization package such as equity offerings. It said that it did not believe that consumer benefits resulted

from subsidized equity participation by consultants, and that such arrangements were purely commercial and designed to secure consultant buy-in. It said that if barriers to entry were lowered through divestment, the prevention of tying, and a ban on consultant incentivization, any new entrant would be able to compete for consultants on the basis of the quality of its facility.

2.315 It said that any breach of the ban on incentives should be reported to the OFT, as with any other illegal anticompetitive behaviour.

2.316 Nuffield said that, if the CC were minded to make an exception for new entrants, this should be limited to new builds only. It said that any such exception should be time-limited or revoked once the costs of building a new facility had been recovered. This would mean that equity incentives would not be possible.

2.317 Nuffield believed that certain de minimis exceptions were sensible, as this would avoid the requirement to calculate fair market rates for services that would never be borne in mind when a consultant was choosing which hospital to base their private practice in. However, it said that only very low value services should be exempt.

- *Ramsay*

2.318 Ramsay said that the key determinant of whether an incentive gave rise to an AEC (which may need to be remedied) was not whether it was 'short term' (eg payment for referrals) or 'longer term' (eg equity participation) but, rather, whether its objective was to seek to reward consultants, directly or indirectly, for sending patients to a particular facility.

2.319 Ramsay reminded us that it had led the way in the UK in ending direct payments to consultants for referrals; it also did not offer equity interests or 'lock in' consultants to

its hospitals. It did, however, offer consultant rooms, administrative support and training to consultants where this improved services to Ramsay's patients. It conceded that such measures could be open to abuse, and it was open to the CC to set out principles which should be applied to such support (for example, not of excessive value; not linked to any requirement to treat patients at the specific hospital; and no financial payment is made to the consultant). It said that such restrictions should be by exception, as designing a framework of permitted support would be difficult. For example, determining the fair market price of administrative support might be difficult, and somebody would need to be given the role of monitoring whether fair market price was being paid, and examining complaints.

2.320 Ramsay said that the CC was 'plainly wrong' to contemplate allowing consultants to take equity stakes in hospitals in situations where this facilitated entry. It said that it was inappropriate for the CC to approve the payment of incentives to interfere with important clinical decisions,<sup>152</sup> whether on the grounds of encouraging new entry or otherwise. It said that it was 'extremely surprised to see the CC even begin to contemplate a remedy along these lines'.

2.321 It said that equity schemes (such as the Circle model) were a means of passing a financial advantage to consultants with the direct intention of influencing their clinical decision-making. It was wrong to think that such schemes could confer patient benefit through promoting new entry. The barrier to new entry (as identified by the CC) arose from the cost of funding new facilities in an environment where there was surplus capacity to meet private patient demand. It said that the Circle model might sustain a new facility but, in reality, simply replaced the same set of consultant providers serving a particular area in an open and competitive environment with a situation where a material proportion of those same consultants were locked in to

---

<sup>152</sup> Ramsay said that the payment of such incentives could fall foul of the Bribery Act 2010.

referring patients to a particular facility. It said that such schemes were not in the interests of patients and might distort competition in the medium term.<sup>153</sup> The remedy was completely incapable of practicable application.

- *Circle*

2.322 Circle endorsed the CC's proposed remedy in principle, but considered that it was important to distinguish clearly between the distortive effects of direct, short-term incentives (cash, in-kind benefits of value like medical secretaries and consulting rooms etc) which should be banned, and long-term incentives likely equity, which also conferred powerful market entry incentives through ownership and value creation.

2.323 Circle believed that the CC's provisional conclusions (in respect of banning equity participations unless they resulted in a reduction in barriers to entry that was likely to be at least as beneficial to competition as any distortion was harmful) required further development and clarification. Specifically:

(a) What factors would be used to assess whether the reduction in barriers to entry was likely to be at least as beneficial to competition as any distortion was harmful?

(b) Who would be responsible for carrying out this assessment, and at what point? Would this be post-entry, when the reduction in barriers to entry was demonstrated by the entry, or pre-entry in order to ascertain whether equity ownership was permissible?

(c) To which health professionals would this apply? Just to consultants, or to others such as GPs (most of whom were co-owners of their practices)?

(d) Should small, clinician-owned clinics be exempt?

---

<sup>153</sup> 



2.324 Circle urged the CC to reconsider the different impacts cash versus equity incentives had on consultant behaviour. It said that if the CC was to persist with the remedy as originally proposed, it would need to provide considerably more guidance as to how such a remedy would be applied.

- *The London Clinic*

2.325 TLC said that a prohibition on incentive schemes to encourage patient referrals was essential. It said that if such a prohibition were considered impractical, or if the prohibition extended only to certain forms of incentive, then it would also support a transparency-based remedy. Such a remedy might require annual disclosure by consultants of all payments or other benefits received from private hospitals or other links with private hospitals. It said that such a 'register of interests' could be administered by the GMC and made available online to PMIs, hospitals, referring doctors and patients. It said there should be no de minimis level. Consultants and GPs should also be required specifically to disclose relevant interests to patients ahead of any decision to refer the patient to a private hospital.

2.326 TLC told us that all existing equity-sharing arrangements in the central London market (and they did not address the market outside central London) should be unwound and that there should be a prohibition on hospitals with significant market power entering into further equity deals.

2.327 It said that, in order to be comprehensive, the remedy should apply to a wider group of medical professionals and service providers. It said that it was concerned about hospital operators acquiring or entering into equity-sharing agreements with important GP practices, as this foreclosed competition and limited patient choice by protecting the existing patient referral pathway to the operator's hospitals.

○ *Kent Institute of Medicine and Surgery Hospital*

- 2.328 The Kent Institute of Medicine and Surgery (KIMS), due to be completed in Maidstone in early 2014, will be an independent tertiary private hospital. KIMS told us that, as it would be the only tertiary hospital in the area (NHS or private), it would be able to provide treatment for patients who would otherwise have had to travel to central London for these tertiary procedures.
- 2.329 It said that 380 consultants had signed or were in the process of signing practising privileges agreements (PPAs) with it pursuant to which they had agreed to transfer some or all of their existing private patient practices to KIMS. KIMS said that, in many cases, patients would be treated by the same consultants that they would have seen in the central London hospitals and that KIMS would be providing local competition to the London private tertiary hospital market currently dominated by HCA.
- 2.330 In the PPAs, KIMS agreed to pay consultants 5 per cent of the revenues received by the hospital for each pathology service, imaging service or surgical procedure ordered or performed by the consultant at KIMS. However, KIMS told us that the PPAs (including the clause providing for these payments) were currently under review. It said the intention was to update the PPAs such that, instead of paying 5 per cent of gross revenues from each service or procedure in cash to the relevant consultant, 5 per cent of net revenues would instead be paid into a specially established trust with independent trustees. The consultant could apply to the independent trustees for a grant against his/her accrued credits, which could be used for research, development and/or teaching. KIMS was concerned that the CC's proposed prohibition on consultant incentives would affect this scheme, which was intended to improve the skills of consultants and ultimately benefit their patients and medicine generally.

2.331 KIMS said that, in order to raise financing for the new hospital, it had had to prove to its funders that a large number of consultants supported the new hospital and were willing to transfer their private practices to it. The funders insisted on consultants providing £5 million worth of personal guarantees of the bank debt and a cash equity investment of £1 million. In return, the approximately 70 consultants who provided guarantees were offered (in total) 5 per cent of the equity in the PropCo (which owns the land and buildings) and the OpCo (which will lease the hospital and operate it), and the 80 cash equity investors were offered (in total) 3 per cent of the equity in PropCo and OpCo. It said that every consultant who signed a PPA and started work at KIMS would share in 2 per cent of the equity in the PropCo and OpCo. KIMS said that, without this equity ownership, the project would in all likelihood never have happened.

- *Nueterra*

2.332 Nueterra Healthcare International (Nueterra) is an operator of hospitals and other healthcare facilities in the USA and told us it had been developing plans to enter the UK and European private healthcare markets.

2.333 Nueterra said that its business model relied on the active participation of consultants in the ownership and management of its healthcare facilities. Its intended model in the UK would see Nueterra owning the majority stake in any facility, with consultants eligible to own up to 49 per cent (typically consultants would have small individual shareholdings of 1 to 3 per cent). These shares would be paid for in cash by the consultants, at fair market value and there would be no commitment to refer patients to Nueterra facilities. When profits were available they would be distributed pro rata to shareholdings, and not in accordance with referrals or revenue generated by individual consultants. Consultants would be expected to make referrals based on what was in the best interests of their patients. Nueterra said that it would expect a

consultant to refer all potential suitable patients to the facility in which he had invested, but there was no obligation on him to do so, nor any direct financial reward by reference to the number of referrals. The only requirement was that the consultant would be obliged to sell his/her shares if he/she stopped practising in the facility. The existence of the consultant's financial interest in the facility would be disclosed and transparent to patients (as is the case, by law, in the USA).

2.334 Nueterra told us that, in its view, its model made for good and innovative management, improved quality and efficiency, and led to better outcomes for patients and their PMIs in terms of price. It said that it believed its model was pro-competitive as it created cost efficiencies and promoted a higher quality of service and facility. If it was not able to secure the active participation of consultants as a result of the CC imposing remedies in line with those proposed in the Remedies Notice, then Nueterra would be much less likely to invest in the UK.

2.335 It said that it supported the CC's intention to ban short-term incentives (eg cash or free office space) to encourage referrals, but that the CC had not sufficiently distinguished between the 'gift' of an equity interest to a consultant in exchange for a binding contract to refer patients to a particular facility, and the cash investment by a consultant into a partnership, to develop and operate a private hospital. It also said that the proposed carve-out for schemes which resulted in a reduction to barriers to entry was vague and difficult to enforce. In Nueterra's view, the CC's proposed remedy was disproportionate and insufficiently targeted on the issues of genuine concern.

- *Aspen*

2.336 Aspen told us it was concerned that we had grouped long-term equity interests in joint ventures together with other incentive arrangements which could be said to be

aimed more directly at providing benefit to consultants in return for patient referrals or commitments to refer patients. It also did not agree that equity investment was an incentive to commission unnecessary or excessive treatment or that equity models were an indirect financial incentive scheme that drove supernormal profits.

2.337 It also said that if only a minority of consultants in a particular specialty in an area entered into an arrangement with a private health provider, there was no evidence that this would prevent entry by another health provider.

2.338 Aspen, which is US-owned, said that it conformed in the UK to the stricter US federal regulations governing illegal remuneration of physicians. It said that experience in the USA had shown that physician-owned healthcare facilities had better healthcare outcomes, shorter stays and significantly higher patient satisfaction ratings than non-physician-owned facilities. Aligning all parties' interests contributed to improved quality of service while driving cost efficiencies and better value for money healthcare. Aspen noted that, in the UK, GPs owned their own premises and the equipment in their surgeries, and consultants sometimes owned their consulting and treatment rooms, daycase surgery facilities and other healthcare facilities including overnight stay facilities.

2.339 Aspen said that, under its model, it retained majority ownership and control of its facilities, and consultants who invested in the equity of a facility were not the only users of that facility. It said that the vast majority of consultants who referred patients to the relevant facilities were not equity investors, and equity investors were not offered preferential terms at the facility. Those who were invited to participate were generally those who were active participants at the relevant facility. Investments were made for cash at fair market value; financial returns were based on the profits of the joint venture and not on the number of patients referred or treated by the consultant;

the arrangement was transparent to patients; and consultants had the ability to sell their equity stake at any time.

- *Others*

- *BMA*

2.340 The BMA agreed that incentive schemes operated by private hospitals which encouraged patient referrals for treatment at their facilities should be prohibited. It was concerned that limiting all incentives might raise barriers to entry for consultants, especially those entering the market.

2.341 It said that the CC's remedy, as proposed in the Remedies Notice, was practicable, though it would be necessary to develop clear criteria for assessing whether the benefits of an incentive scheme outweighed any distortions it might create. It thought that this would enable a private hospital provider to commission an independent assessment of the benefits of any scheme. It was in favour of transparency within the hospital and local area (and as between consultant and patient) about any incentive arrangements which were thus permitted. It said that oversight to ensure the remedy was met should be light touch and constitute no more than a commitment, as part of annual CQC registration, that the hospital provider had not entered into inappropriate arrangements with consultants and that any scheme had been independently assessed. Medical Advisory Committees could also have a role in monitoring and enforcing the fair market price test through a sector-wide arbitration mechanism.

2.342 The BMA said that some hospitals provided free or reduced-cost consulting rooms and secretarial support to consultants while they were establishing their practice, and that some consultants might find the initial cost of entering the market prohibitive if this were not permitted. It said that, in order to avoid an AEC, hospitals should offer these schemes equitably to new consultants and for a limited time period only.

2.343 While the BMA supported the prohibition of incentives, it did not believe that these were so widespread that complex regulation was necessary. It said that the private provider market in some areas was so small that regulation might be impracticable. It also said that the interface between the NHS and private healthcare in this context was unique to the UK (for example, would a consultant treating a patient in the NHS hospital where he/she worked constitute a conflict?). The BMA favoured working with the GMC to develop a campaign to ensure that consultants were aware of their obligations under their professional standards.

2.344 On equity-sharing arrangements, the BMA said that it might be necessary to grandfather existing arrangements to avoid inadvertently destabilizing the market. It also said that, historically, a number of private hospitals had been set up or initiated by local consultants in response to need, and it would be unreasonable for consultants to be prevented from investing in the provision of healthcare which increased provider competition and ultimately drove down costs. It said that safeguards should be by robust regulation, and not prohibition which would lead to uncontrolled circumventions.

#### *Approaches to clinician incentives in other jurisdictions*

2.345 Following publication of the Remedies Notice, the CC carried out some further research into laws on physician incentives in the USA and also looked at the position in Canada and Australia. The results of this research are set out in Appendix 2.7 and summarized below.

##### *The USA*

2.346 In the USA, payments to doctors for referring Medicare or Medicaid patients to particular facilities for in-patient treatment are illegal under the Anti-Kickback Law. This applies to anyone who 'knowingly and willingly offers, pays, solicits or receives

remuneration in order to induce business reimbursed under the Medicare or Medicaid programs'. However, prosecutions under the Anti-Kickback Law were rare as the 'knowingly and wilfully' standard was very difficult to satisfy, so the legislation was supplemented by the Stark Acts.

2.347 The Stark Acts banned referrals of Medicare and Medicaid patients for clinical laboratory services and certain designated medical procedures where the referring physician has a financial relationship with the laboratory or clinic. Like the 'Anti-Kickback Law', the Stark Acts contain numerous exceptions, including an exemption where the ownership interest of referring physicians is minimal. The 2010 Affordable Care Act (so-called 'Obamacare') tightened the restrictions further, particularly in the case of referrals to hospitals in which the physician owned an equity interest (although pre-existing equity arrangements were grandfathered).

2.348 While there have been many prosecutions under the legislation, a common complaint is that it is complex, riddled with exceptions, and monitoring compliance with it is costly. Because the laws set out very precisely what can not be done, they also open up loopholes where incentives can be applied. As a result, US regulators regularly issue revised regulations and guidelines to try and close down these loopholes.

### *Canada*

2.349 In Canada, healthcare is largely publicly funded;<sup>154</sup> 99 per cent of physician expenditures in Canada come from public sector sources. Doctors and clinics providing private medical care are not permitted to charge fees any higher than those payable under Medicare unless they are treating non-Medicare insured persons or providing services which are not available under Medicare. Doctors can refer patients for tests to be carried out in clinics they own or have a financial interest in, and there

---

<sup>154</sup> The Canadian public health system is known as Medicare.



are no laws prohibiting doctors from owning equity in hospitals or clinics, or from referring patients to hospitals in which they are invested. However, no new private hospitals may be built in Canada, although this restriction does not apply to smaller, specialized medical facilities.

### *Australia*

2.350 In Australia, approximately 70 per cent of total health expenditure is funded by government. The public system, known as Medicare, typically covers 100 per cent of in-hospital costs, but only a proportion of the cost of seeing a general practitioner and specialist services. The Government subsidizes private health insurance premia (on a sliding scale according to age and income) and nearly half the population is insured for hospital and/or ancillary benefits. It is a criminal offence to solicit or pay referral fees for admission to a hospital (provided the patient is covered by PMI) or for pathology or diagnostic imaging services. There are restrictions on GP practices leasing space to pathology providers at inflated rents (ie the pathology providers may not provide a financial incentive to doctors through this route) and, since 2010, patients may take test requests to a pathology practitioner of their choice. The direct involvement of consultants in hospital management and ownership is uncommon in Australia but it is permitted and does occur.

## *Regulatory environment in the UK*

### *General Medical Council*

2.351 The UK regulatory regime applying to doctors and hospitals is set out in the provisional findings (paragraphs 2.61 to 2.88). The conduct of doctors in relation to financial incentives and conflicts of interest is regulated by the GMC.<sup>155</sup>

---

<sup>155</sup> The Bribery Act 2010 may also apply—see paragraphs 2.359–2.362.

- 2.352 The GMC registers doctors to practise medicine in the UK.<sup>156</sup> It is overseen by the Professional Standards Authority for Health and Social Care, a statutory body responsible to Parliament and charged with promoting best practice and consistency in professional self-regulation in nine bodies responsible for different branches of the healthcare profession across the whole of the UK.
- 2.353 To treat patients, a doctor must be registered with the GMC and have a licence to practise. Since December 2012, doctors have had to renew their licence periodically through revalidation, the process by which doctors must demonstrate to the GMC that they are up to date and fit to practise.<sup>157</sup>
- 2.354 The GMC publishes advice to doctors on the standards expected of them. All doctors must follow the advice given in the GMC's *Good Medical Practice*<sup>158</sup> and its explanatory guidance, which includes advice on avoiding and dealing with conflicts of interest.
- 2.355 The GMC's *Good Medical Practice*, which was updated in April 2013, precludes doctors from accepting any inducement, including financial incentives, that may affect or be seen to affect the way that they treat or refer a patient or commission services—if they have a financial interest in a hospital or clinic to which they plan to refer a patient, this must be disclosed to the patient and recorded in the patient's notes.<sup>159</sup>

---

<sup>156</sup> [www.gmc-uk.org/about/index.asp](http://www.gmc-uk.org/about/index.asp).

<sup>157</sup> [www.gmc-uk.org/doctors/licensing.asp](http://www.gmc-uk.org/doctors/licensing.asp).

<sup>158</sup> [www.gmc-uk.org/guidance/good\\_medical\\_practice.asp](http://www.gmc-uk.org/guidance/good_medical_practice.asp).

<sup>159</sup> Good Medical Practice, paragraph 78: 'You must not allow any interests you have to affect the way you prescribe for, treat, refer or commission services for patients.' Paragraph 80: 'You must not ask for or accept—from patients, colleagues or others—any inducement, gift or hospitality that may affect or be seen to affect the way you prescribe for, treat or refer patients or commission services for patients. You must not offer these inducements.' The associated guidance notes state, at paragraph 17: 'If you plan to refer a patient for investigation, treatment or care at an organisation in which you have a financial or commercial interest, you must tell the patient about that interest and make a note of this in the patient's medical record.'

- 2.356 The GMC's *Good Medical Practice* does not have the force of law. However, the GMC does have a range of sanctions that it may apply in the case of serious or persistent failure to follow its guidance: it may issue warnings to doctors, restrict the doctor's registration, suspend (for a period of 12 months) or erase a doctor from the medical register if it finds that a doctor's fitness to practise is impaired. Any such decision by the GMC can be appealed for judicial review.
- 2.357 The GMC does not directly monitor doctors' day-to-day activities, but will act on information or complaints received suggesting that a doctor has failed to act in a way consistent with the principles and standards of good practice set out in its guidance. The GMC told us that it received few complaints about incentives offered to or accepted by doctors or financial conflicts of interest.
- 2.358 The GMC told us that its work was increasingly focused on maintaining and improving standards of education, including the revalidation programme,<sup>160</sup> which had relevance for all of the 240,000 doctors that were on its register rather than, as in the past, on the 2 to 4 per cent of doctors who were guilty of serious professional misconduct. It told us that, of its approximately 900 staff, 30 were involved in the fitness to practise regime.

#### *Bribery Act 2010*

- 2.359 The Bribery Act 2010 (the Bribery Act)<sup>161</sup> creates a range of new offences relating to corruption which could have application to incentive schemes aimed at doctors. HCA, for example, told us that it had revised the terms of some of its agreements with doctors in order to ensure compliance with the Bribery Act.

---

<sup>160</sup> See the GMC's description of this process.

<sup>161</sup> The Bribery Act applies to all parts of the UK (s.12(1)). Though justice is normally a devolved matter, the Act has been applied to Scotland by means of a legislative consent motion.

- 2.360 The test of whether or not the payment of a referral fee is an offence under the Bribery Act turns on whether or not a reasonable person in the UK would think that such a fee represented an effort to induce performance which was contrary to good faith, partial, or in breach of trust.
- 2.361 There are two difficulties involved in determining whether or not any particular incentive scheme would be caught by the Bribery Act:
- (a) The first is that the Bribery Act is a relatively new piece of legislation and, as a result, there is a paucity of case law concerning it. We have not found any that represents helpful guidance in this instance.
  - (b) The second is that the Bribery Act employs the perspective of the reasonable person in the UK. As such, this will be a question left to the individual jury.
- 2.362 It seems plausible that a jury could find that the provision of referral fees did constitute an offence. In particular, it seems possible that a jury could find that consultants ought to exercise their power of referral impartially and that a referral fee encouraged them to do so partially.

### *Assessment*

- 2.363 In this section, we first describe the types of incentive schemes that had been adopted by hospital operators and then go on to consider what remedial measures it would be necessary and appropriate to apply to deal with the AEC that we have provisionally found.

#### *Types of incentive scheme*

- 2.364 As noted in our provisional findings, we found a very wide range of schemes operated by hospitals which were likely to encourage consultants to treat patients at their facilities. We distinguish here between these on the basis of how closely the

schemes link an individual consultant's behaviour to the provision of a reward since we thought this would be informative for our remedies.

- *Incentives and their influence on behaviour*

2.365 We reasoned that all incentive schemes provided by hospital operators had the potential to distort competition between hospitals for referrals but that some were more likely to do so than others. We thought, for example, that direct incentives were more likely to do so than indirect incentives and that where rewards are 'pooled', the fewer individuals who share these rewards the more likely it is that the scheme will affect their conduct. We first discuss direct incentives.

- *Direct incentives*

2.366 We use the term 'direct incentives' to describe schemes or arrangements between hospital operators and clinicians which link, implicitly or explicitly, the value of the rewards provided to a clinician to the value of that individual clinician's conduct to the hospital operator. In other words, there is a linkage between an individual clinician's actions and the value of the rewards he or she receives as a result. Where a clinician could influence the size of their own reward by altering their behaviour we thought that they would be more likely to do so than if their reward depended on the behaviour of a larger group of clinicians as in schemes where rewards are pooled.

2.367 Some examples of direct incentive schemes that we have found are listed below:

- (a) cash payments made to clinicians for each patient referred or test commissioned;
- (b) payments made to clinicians equivalent to a set share of revenues generated from each patient referred for tests or treatment;
- (c) hospital profit share schemes through which the consultant receives a share of the hospital's overall profits depending on the amount of revenue he or she has generated for the hospital;

- (d) equity participation schemes where the value of shares allocated to a consultant is based on the revenue they generate at a hospital; and
- (e) schemes providing consultants with discounted or free use of consulting rooms, secretarial and other administrative services where the value of the benefits provided is, implicitly or explicitly, linked to the amount of revenue generated by the doctor concerned.

- *Indirect incentives*

2.368 We use the term ‘indirect incentives’ to refer to schemes or arrangements between a hospital operator and clinicians where there is no linkage between an individual clinician’s behaviour and the reward he or she receives. These might take the form of benefits where no distinction whatsoever is made between the rewards allocated to clinicians, say an event to which all consultants practising at the hospital are invited.

2.369 We would also include within this category schemes adopted by hospital operators which grant or permit clinicians to purchase an equity stake<sup>162</sup> in a hospital to which they refer patients or at which they practise. We have found this to be increasingly common, particularly in the context of new hospital launches, though the practice also extends to circumstances in which a hospital effectively ‘buys into’ a group practice of clinicians.

2.370 Typically in these arrangements, the size of the collective stake owned by clinicians is limited to 49.9 per cent, so the hospital operator always retains control (though some clinician shareholders may be involved in the hospital’s management in various ways). In the case of a hospital, an individual clinician’s stake is typically low (around 1 to 3 per cent) although in some cases, for example where the joint venture relates to the ownership of a single piece of high value equipment, an individual clinician’s

---

<sup>162</sup> The forms of business entity used for this purpose vary and could include, for example, the establishment of a LLP comprising the hospital operators as a member and a number of doctors.

stake may be higher.<sup>163</sup> The clinician will be entitled to his or her pro rata share of dividends,<sup>164</sup> if any, declared by the hospital (or the company owning/operating the piece of equipment). In arrangements such as this, rewards are, effectively, 'pooled' and shared out irrespective of the clinician's individual contribution to the entity's performance. Clearly, where the pool is small, say just a few clinicians, the scheme's benefits will more closely mimic those offering direct incentives. We return to this issue later.

2.371 The equity stake may be paid for up-front in cash at fair market value, or the hospital (as is the case with Circle's equity scheme) may defer payment for the shares until such time as the shares are sold. Some schemes may allow the clinician to sell the shares at any time for fair market value, while others may only contemplate the clinician selling his shares upon, for example, his death, incapacity, retirement, moving away from the area, or ceasing to participate in the management of the facility (or ceasing to be members of the joint venture partnership).<sup>165</sup> In many (though not all) cases we found that clinicians with equity shares in a hospital also enter into agreements with the hospital operator which oblige them to:

- (a) use their best endeavours to treat patients at the hospital concerned or order tests there, subject to the patient's best medical interests and the GMC guidelines; or
- (b) in the case of Circle's agreements, to commit to undertake a certain proportion of their private work, usually around [25%], at the hospital.

We also found that the purchase of equity in a hospital might, as was the case with KIMS, be associated with or linked to participation in an incentive scheme.

---

<sup>163</sup> In such cases the link between the usage of the piece of equipment concerned and the reward accruing to the doctor will be more direct and may even resemble pay-per-click.

<sup>164</sup> Or distributions in the case of partnerships.

<sup>165</sup> [25%]

2.372 We thought it was important to distinguish between these two elements of hospital arrangements with clinicians, ie equity participation and referral obligations, and to understand the relative importance of each in influencing clinician behaviour.

2.373 We reasoned that, although the ownership by a clinician of a small stake in a hospital might induce him or her to refer patients there even if there was an alternative hospital of better quality, the existence of a contractual obligation to do so, even if caveated by reference to the best clinical interests of the patient, would be a far more powerful influence. We therefore considered that agreements by clinicians to commit to using a hospital were more likely to give rise to competition concerns than small-scale share ownership though we acknowledge that, in practice, the two have been linked.

### *Design considerations*

2.374 In this section we consider the nature and level of constraints that we think should be applied to different types of remedy and how the remedy should be designed to achieve these aims. We then conclude on the remedy's effectiveness and proportionality.

2.375 Our provisional AEC finding related solely to incentive schemes between private hospital operators and clinicians and therefore we do not consider that the remedy should extend to any arrangements which involve only clinicians, or between clinicians and other parties such as insurers, or private healthcare providers other than private hospital operators.

### *Services of low value*

2.376 We began by considering whether there was a level below which the value of any service or benefit offered or provided to a clinician would be likely to have no effect



on his/her behaviour and would therefore not constitute an incentive. We thought that if there were, and if the provision of such services could be excluded from our remedy, then the regulatory burden of ensuring compliance on private hospital operators and clinicians could be reduced without lessening the effectiveness of the remedy. On the other hand, we recognized that a de minimis limit could give rise to enforcement problems in ascertaining whether, for example, a service or benefit which it was claimed fell below this threshold did so.

2.377 We thought that if the maximum value of the service provided was set at a very low level and declared on the hospital's website then, even if disagreements did arise over the value of a service being provided, the risk to the effectiveness of the remedy would be low since the likelihood that services so inexpensive would influence doctor behaviour would also be low. We thought that a limit low enough to permit private hospitals to offer doctors free tea and coffee, newspapers and magazines, stationery, general marketing and in-house training, for example, would be appropriate. We provisionally decided that an upper limit of £500 a year (equivalent to less than 1 per cent of a consultant's NHS starting salary) on the cumulative value of such services that an individual hospital could provide to a clinician would be reasonable. In order to achieve transparency we decided that the services of this nature which a private hospital was providing to clinicians and which it claimed fell below our limit should be disclosed on the hospital's website.

#### *Services of higher value*

2.378 We next considered services with a higher value (for example, the provision of consulting rooms, secretarial and administrative services, contributions to professional indemnity insurance, and parking spaces). We thought that private hospital operators should continue to be able to offer doctors services of a higher

value but subject to certain conditions in order to ensure that the service did not constitute an implicit incentive to refer patients to the hospital(s) concerned.

2.379 We thought that where the cumulative value of all services provided to a clinician by a private hospital group exceeded £500 a year, anything in excess of the £500 limit should be:

- (a) charged to the clinician at their fair market value;
- (b) potentially available to all clinicians with practising rights at the hospital rather than allocated selectively with preference being given, for example, to those liable to generate high levels of revenue; and
- (c) disclosed on the private hospital operator's website (by hospital) together with the market value that the hospital operator imputed to each service.

2.380 We also thought that, where a clinician provided services to a private hospital in exchange for remuneration, for example by taking up a part-time position,<sup>166</sup> then the private hospital should disclose on its website the payments made to individual post-holders and a summary of the duties performed by each post-holder on behalf of the private hospital.<sup>167</sup>

#### *Schemes which incentivize patient referrals*

2.381 We next considered what remedies it would be appropriate to apply to schemes operated by private hospitals which are designed to or have the effect of inducing doctors (whether consultants or GPs) to refer patients to the scheme operator's hospitals, even when subject to various caveats and carve outs.

---

<sup>166</sup> This provision is not intended to cover a situation where a hospital charges a self-pay patient or PMI a packaged fee for a procedure and then reimburses the consultant with his normal fee from the packaged fee.

<sup>167</sup> This should not consist merely of the title of the post held by the consultant, for example, but should include a summary list of the duties performed by (or responsibilities of) the consultant consequent upon holding that post.

2.382 We thought that any scheme operated by a private hospital operator, whether contractual or not, which provided an inducement to, or created an obligation on, a clinician to treat or refer patients for tests at its hospital or hospitals should be prohibited outright. For the avoidance of doubt we would include here arrangements which are caveated with an overriding obligation always to act in the patient's best medical interests or adhere to GMC guidelines on good practice. We considered that such arrangements inevitably create a tension between the clinician's professional obligations to his patient and his financial interest and distinguishing between referral behaviour driven by one or the other would be very difficult in practice. We therefore decided that an outright ban would be the simplest and most effective way of solving the competition problems arising from these arrangements.

#### *Equity participation schemes*

2.383 We next considered schemes through which clinicians acquired an equity stake in a vehicle or entity created by a hospital operator. We thought that such schemes could, by aligning the interests of the clinician with those of the private hospital, create an incentive for clinicians participating in them to treat patients at or to refer patients to the hospital or facility concerned for tests.

2.384 We saw several forms of such schemes which were often, though not always, associated with the launch of new private hospitals, for example Circle's hospitals in Bath and Reading, KIMS in Maidstone and the Spire Montefiore hospital in Hove. Other examples of such arrangements not associated with new hospital launches would include various partnerships and joint ventures that HCA has entered into with groups of consultants, for example the LOC.

2.385 We considered whether it would be appropriate to ban such arrangements outright or to prohibit consultants with a financial interest in a private hospital from referring or

treating patients there, on the lines of the US legislation. However, private hospital operators as well as two of the insurers had argued that some of these arrangements were beneficial to competition and to patients. It was put to us that they encouraged consultants to become engaged in the running of the hospital which could facilitate innovation in treatment and a focus on the quality of care being provided.

2.386 Circle in particular said that there was a growing body of evidence that clinical leadership and engagement improved the quality of care and cited a number of studies including those undertaken by the King's Fund and McKinsey which supported this view.<sup>168</sup> It said that when consultants were given not simply a 'say' in how care was delivered but meaningful operational and decision-making power, it ensured that the care patients received was determined by the individuals best placed to make that determination.

2.387 Aviva submitted very similar arguments. It said that it thought equity schemes could be positive because they engaged consultants in decision-making and gave them an interest in ensuring that the hospital delivered the appropriate quality of care to patients. However, Aviva said that where shares were given to a consultant, rather than sold, then first, this beneficial effect would be lessened, and second, there would be a real risk that decisions about patient care would be distorted.

2.388 We noted that in the case both of the new private hospital launches, and situations where a private hospital operator had bought into a consultant group, the private hospital operators concerned had required clinicians to either enter into an obligation to refer patients to the hospital or had offered them a direct incentive to do so. This indicated to us that the ownership of shares in a hospital *per se* may not constitute a particularly strong incentive to clinicians to treat patients there since hospital owners

---

<sup>168</sup> See, for example, When Clinicians Lead, McKinsey Quarterly, February 2009.

had either funded incentive payments to encourage them to do so or sought contractual agreements to oblige them to refer patients to the hospitals concerned. We thought, therefore, that incentive and referral agreements with clinicians, of the type which we have proposed should be banned, were likely to exert a greater influence on clinicians than equity participation itself, certainly at a low level of shareholding.

2.389 We thought, however, that schemes where the pool of rewards was shared between a small number of clinicians and where an individual clinician's conduct, for example referral or the commissioning of tests, could affect the performance of the business entity, more closely resembled the direct incentive schemes that we provisionally decided should be banned. We thought that it was important to distinguish between schemes like this, which could give rise to competition concerns, and equity participation arrangements where clinicians have a relatively small share of the business.

2.390 We have also in our analysis distinguished between schemes in which a private hospital operator retains a large, and usually a controlling, interest and arrangements which clinicians set up among themselves with no private hospital operator involvement.

2.391 We provisionally decided that equity participation schemes between private hospital operators and clinicians practising at or referring patients to the hospitals concerned should be allowed, subject to the conditions listed below. We provisionally decided that existing schemes which do not meet these conditions should be unwound (or suitably amended) within a period of six months from the date of our final Order arising from this inquiry. The conditions are:

- (a) the equity stake must be paid for by the clinician up front and at fair market value.<sup>169</sup> The funding of the purchase by a loan from the private hospital, or deferral of payment until the shares are sold, would not be permitted;
- (b) where a company which owns, directly or indirectly, one or more hospitals is involved (ie the equity participation is a stake in a hospital, or in a joint venture in which a private hospital also has a stake<sup>170</sup>) then the equity stake of any individual clinician with practising rights at or the ability to commission tests at the facility concerned should be limited to 3 per cent. The proposed limit on the size of the shareholding is set at a level where we consider it is sufficiently small (and remote) so as to be unlikely to influence the clinician's referral or commissioning behaviour while still providing for an ownership stake to encourage clinician engagement in the setting up and running of the private hospital;<sup>171</sup> and
- (c) the acquisition of an equity stake must not be linked to any requirement on the clinician, express or implied, to refer patients to the private hospital or to conduct a minimum percentage of his private practice at that hospital, or to practice at that hospital for a minimum period, or to commit to providing a given level of throughput in the case of a specialized piece of equipment.

2.392 We further propose that private hospital operators be required to disclose publicly via their websites which, if any, clinicians practising at their hospital own equity in their facilities (or in equipment within those facilities).

---

<sup>169</sup> The question remains: how should 'fair market value' upon the purchase or sale of a stake be determined, using what methodology, and whether this needs to be overseen in some way by a regulator. The use of a pre-set formula in a JV agreement for determining fair market value should be acceptable, provided that the formula is reasonable.

<sup>170</sup> This would cover, for example, clinics part-owned by clinicians and part-owned by a private hospital group, or individual items of diagnostic equipment or equipment used for treating patients which are part-owned by clinicians and part-owned by a private hospital group.

<sup>171</sup> The remedy would thus permit a small number of clinicians to own a stake in, for example, an expensive piece of radiotherapy equipment but each clinician's stake would be limited to 3 per cent.

## *Oversight*

2.393 The remedy that we have provisionally decided to adopt here should not prove complex or expensive to monitor. For the most part it consists of outright bans on certain forms of conduct, a breach of which would be relatively easy to define. Where not banned, for example the provision of benefits of low value or higher value benefits which have to be charged for at fair market value, the transparency provisions that we have proposed should render them open to challenge by interested parties, including competitors and PMIs.

2.394 We envisage that the OFT/CMA, would have responsibility for ensuring the compliance of the private hospital groups with the remedy. The other candidate that we considered for this role, Monitor, while having considerable expertise in the healthcare sector has no jurisdiction outside of England whereas the OFT has UK-wide jurisdiction. We also envisage that the OFT/CMA will notify the GMC of any incentives which come to its attention which are in breach of the Order and/or which it considers may be incompatible with the GMC's good practice guidelines.

## *Conclusions on effectiveness*

2.395 As stated in paragraph 2.365, we thought that direct incentives were more likely to result in distortions to competition between hospitals for referrals than indirect incentives. We considered that banning all direct incentives, subject to a de minimis exception, would be effective in addressing the AEC that we have provisionally found. We further considered that limiting indirect incentives, by making them subject to the conditions set out in paragraph 2.391, would ensure that the size of any financial incentive on a doctor to make a referral would be sufficiently small, and the reward sufficiently remote, as to make it unlikely to exercise a material influence on an individual doctor's decision on where to refer a patient or what diagnostic tests to order, for example. For this reason, we considered that this remedy would be

effective in addressing the remaining part of the AEC that we have provisionally found.

### *Proportionality*

2.396 In making our assessment of proportionality, we are guided by the principles set out in paragraph 1.16.

### *Benefits*

2.397 The 'legitimate aim' of this remedy is to ensure that competition between hospitals for patients is carried out on the basis of the quality and price of the healthcare services they offer rather than the value of inducements paid to doctors to encourage referrals. As stated in paragraph 2.395, we think the remedies that we have set out here will be effective in addressing the AEC that we have provisionally found.

2.398 In addition we have recognized that certain aspects of the conduct over which we have competition concerns result in customer benefits and sought to maintain these. We have, for example, sought to retain the benefits of consultant engagement associated with equity participation and the positive effect this can have on market entry whilst addressing their potentially negative effects on consultant incentives.

### *Costs*

2.399 We do not consider that the costs of monitoring this remedy will be significant. For the most part the remedy consists of an outright ban on certain forms of conduct, breach of which should be fairly easy to identify. Where our remedy falls short of an outright ban we have accompanied it by transparency requirements which would enable interested parties, including competitors and PMIs, to bring potential infringements to the attention of the OFT/CMA.



- 2.400 It is not clear to us that the outright ban on incentive schemes that we have proposed will result in any costs to the parties. The large hospital groups abandoned the more straightforward cash-based payments to doctors in 2011 and 2012 as the OFT's and later the CC's investigations got under way.
- 2.401 Similarly, in respect of benefits provided to doctors such as consulting rooms and secretarial services, because hospitals will be required to charge a fair market value for them in future, this will reduce rather than increase their costs.
- 2.402 To the extent that cash payments or benefits in kind were intended to encourage referrals, we considered that clinicians would not have been permitted to accept them under the GMC good practice guidelines, and so we considered that it would be inappropriate to take account of either the benefits which such schemes conferred on private hospitals (in the form of additional referrals) or the costs to clinicians of forgoing such payments. This remedy is intended to encourage competition between private hospitals on the basis of quality of service, and we considered that it would take only a very small increase in service quality to outweigh the costs to clinicians.
- 2.403 The remaining costs to the parties arising from these remedies will relate to the unwinding of or amendments to equity sharing, joint venture or equivalent arrangements. These might, for example, require a private hospital group to buy back shares from clinicians so as to reduce their share to the level we have proposed. Alternatively, since our restrictions apply to entities jointly owned by private hospitals and clinicians, rather than clinicians alone, the clinicians concerned in these may choose to buy out the private hospital group. Either way, we think that if these transactions take place at fair market value, they will be broadly neutral.

### *Conclusions on proportionality*

2.404 We provisionally decided that the remedy we have proposed was proportionate, in that it retained the customer benefits of clinician engagement associated with equity participation and did not impose significant relevant costs on either private hospitals operators or clinicians.

### *Conclusions on Remedy 4*

2.405 We have provisionally decided, for the reasons set out here, to ban direct incentives (subject to a £500 a year de minimis exception) and to place conditions on equity participations by doctors in either private hospitals or joint ventures involving companies which own or operate a private hospital. We recommend that the OFT/CMA should monitor and enforce compliance with this remedy by private hospitals.

## ***Remedies 5–7: Information on consultant and hospital performance***

### *Introduction*

2.406 In our provisional findings we identified two areas in which insufficient publicly available performance information gave rise to AECs in the provision of privately funded healthcare services:

We identified the lack of sufficient publicly available performance (and fee) information on consultants as a conduct feature in the provision of privately funded healthcare by consultants. This feature gives rise to an AEC due to the distortion of competition between consultants by preventing patients from exercising effective choice in selecting the consultants by whom to be diagnosed and treated. This reduces competition between consultants on the basis of quality and price.

We also identified the lack of sufficient publicly available performance information on private hospitals as a conduct feature in the provision of privately funded healthcare by hospitals. This feature gives rise to an AEC due to the distortion of competition between private hospital operators by preventing patients from exercising effective choice in selecting the private hospitals at which to be treated. This reduces competition between private hospital operators on the basis of quality and price.<sup>172</sup>

2.407 In the Remedies Notice we proposed two remedies that we considered would address the lack of information on consultant and hospital performance. In this section we first describe our initial proposed performance remedies as set out in the Remedies Notice and then we summarize the responses that we have received from the insurers, the private hospital operators, Private Healthcare Information Network

---

<sup>172</sup> [Provisional findings](#), Section 10.

(PHIN) and other interested parties in response to the Remedies Notice.<sup>173</sup> Finally, we set out provisional decision on the remedy, together with a discussion of the likely effectiveness and proportionality of the remedy.

### *Consultant performance information*

2.408 Remedy 5 in the Remedies Notice addressed the lack of information available to patients on consultant performance and provided for:

A recommendation to the health departments or their equivalent bodies in Scotland, Wales and Northern Ireland that they collect and publish on their most appropriate patient-facing website individual consultant performance indicators to include activity and clinical quality measures across the same or an equivalent range of medical specialties to that included in the NHS England scheme.

### *How proposed Remedy 5 may have addressed the AEC*

2.409 As set out in the Remedies Notice, we considered that proposed Remedy 5 would address the AEC identified in our provisional findings by increasing the availability of information on consultant performance, allowing patients to make meaningful choices between consultants. In this context, we interpret ‘quality’ broadly to include both ‘hard’ measures of performance, such as mortality or infection rates, as well as ‘softer’ measures, such as providing clear explanations of complex medical issues. By making suitable information on consultant quality available, we considered that Remedy 5 should stimulate competition between consultants on the basis of the quality of service they provide to patients driving improvements in the quality of private healthcare services in the UK.

---

<sup>173</sup> These responses have been gathered from written submissions, informal meetings, and formal hearings.

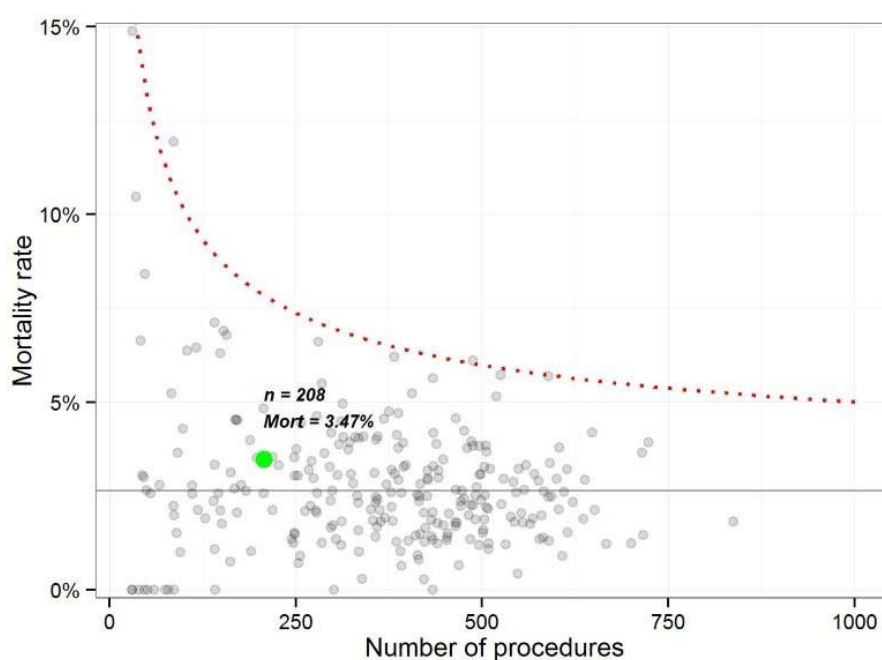
## Background

2.410 NHS England started publishing data on consultant outcomes in summer 2013.<sup>174</sup>

The initial data published was collected by professional bodies<sup>175</sup> representing ten medical specialties and provided details of one or more performance measure for each of approximately 18 procedures. For example, Figure 1 shows the information provided on mortality rates for one of the cardiac surgeons practising at the Barts Health NHS Trust for the three-year period between April 2009 and March 2012. This shows how many procedures the consultant has carried out over the period, together with the mortality rate of his patients relative to those of other consultants in the same specialty. It also indicates the average mortality rate (light grey line) and—via the red dotted line—the level at which a consultant's mortality rate becomes (statistically) significantly higher than the average.

FIGURE 1

### Risk-adjusted mortality rates for cardiac surgery



Source: [Society for Cardiothoracic Surgery in Great Britain and Ireland](#).

<sup>174</sup> [www.nhs.uk/choiceintheNHS/Yourchoices/consultant-choice/Pages/consultant-data.aspx](http://www.nhs.uk/choiceintheNHS/Yourchoices/consultant-choice/Pages/consultant-data.aspx).

<sup>175</sup> These included, inter alia, the Society for Cardiothoracic Surgery in Great Britain and Ireland, the British Association of Head & Neck Oncologists, the British Association of Urological Surgeons, the British Orthopaedic Association, the British Hip Society, the Association of Coloproctology of Great Britain and Ireland, and the British Association for Surgery of the Knee.

2.411 Table 7 summarizes the information published by NHS England. This highlights that some of the data published by NHS England covers consultants and hospitals in the other nations of the UK, whilst other datasets do not.

TABLE 7 Summary of NHS England initiative coverage

<i>Specialism area</i>	<i>Dataset description</i>	<i>Number of procedures covered</i>	<i>Geographic coverage</i>	<i>Number of consultants published</i>
Adult cardiac surgery	<ul style="list-style-type: none"> <li>Number of patients (2011)—34,760</li> <li>Coverage across NHS and private hospitals</li> </ul>	4	England and Wales	279 consultants
Vascular surgery	<ul style="list-style-type: none"> <li>Number of patients (2008–2012 annual average)—4,250</li> <li>Coverage across all NHS hospitals and some private hospitals</li> </ul>	2	England (all) Scotland, Wales, and Northern Ireland (subset who have consented)	<ul style="list-style-type: none"> <li>Elective repair of an infra-renal abdominal aortic aneurysm—458 consultants</li> <li>Carotid endarterectomy—429 consultants</li> </ul>
Thyroid and endocrine surgery	<ul style="list-style-type: none"> <li>Number of cases (2009–2012 annual average)—4,400</li> <li>7 indicators covered including—eg in-hospital mortality, length of stay, rate of exploration for bleeding, readmission rate</li> </ul>	1	UK	125 consultants
Bariatric surgery	<ul style="list-style-type: none"> <li>Number of primary operations recorded (2012/13)—4,389</li> <li>Coverage across NHS hospitals only</li> </ul>	3	England	106 consultants
Interventional cardiology	<ul style="list-style-type: none"> <li>Number of Percutaneous Coronary Intervention (PCI) cases (2011)—88,962</li> <li>Coverage across NHS hospitals and some private hospitals</li> </ul>	1	UK	Approximately 600 individual PCI operators are listed on website
Orthopaedic surgery	<ul style="list-style-type: none"> <li>Number of cases (2012)—150,000</li> <li>Coverage across NHS hospitals</li> </ul>	2	England, Wales, and Northern Ireland	1,594 consultants
Urological surgery	<ul style="list-style-type: none"> <li>5,449 cases (including 125 private patients from 34 consultants)</li> <li>Coverage across NHS hospitals and some private hospitals</li> </ul>	1	England	283 consultants
Colorectal surgery	<ul style="list-style-type: none"> <li>27,751 cases (2010–2012)</li> <li>Coverage across NHS hospitals</li> </ul>	1	England	667 consultants
Upper gastro-intestinal surgery	<ul style="list-style-type: none"> <li>Number of patients (2011/12)—2,381</li> </ul>	2	England and Wales	163 consultants
Head and neck cancer surgery	<ul style="list-style-type: none"> <li>Number of cases (2010/11)—6,879</li> <li>Coverage across NHS hospitals only</li> </ul>	N/A	England and Wales	c.300 consultants
<b>Total</b>		<b>&lt;20</b>		<b>&lt;4,000</b>

Source: [Bupa response to the Remedies Notice](#), Table 5.

*What the parties told us*

2.412 We invited views on the likely effectiveness of the proposed Remedy 5, including whether it was practicable in all of the nations and whether the list of specialties covered and indicators currently published were appropriate.

- *PMIs*

2.413 Bupa expressed concerns that the remedy proposed by the CC would be neither effective nor sufficient in terms of helping patients and/or PMIs to make better decisions. Bupa noted that:<sup>176</sup>

- (a) the coverage of the current NHS England initiative was limited with only ten out of 65 specialties and 4,000 consultants involved;
- (b) outcome indicators were typically provided for only one or two procedures within a specialism;
- (c) the outcome indicator used was generally the risk-adjusted mortality rate which was, in many cases, not an appropriate basis on which to distinguish between consultants; and
- (d) the information was not provided in a format that was easily accessible<sup>177</sup> to either patients or PMIs.

2.414 Bupa also highlighted concerns about the practicality of the remedy noting that it shifted the responsibility and costs on to the NHS, and therefore on to taxpayers, rather than private providers. Given existing resource constraints on the NHS and the current wave of reforms, this may mean that a significant period of time elapsed before private patients could benefit from improved information.<sup>178</sup>

---

<sup>176</sup> [BUPA response to the Remedies Notice](#), paragraph 6.22.

<sup>177</sup> In particular, BUPA highlighted that in its current format, the PMIs were unable to analyse the underlying raw data.

<sup>178</sup> [BUPA response to the Remedies Notice](#), paragraph 6.25.

- 2.415 Bupa also highlighted the need for performance data, both on consultants and on hospitals, to be available to PMIs in a format which would allow them to carry out a range of more technical analysis on behalf of their customers. This would take the form of access to the raw datasets underlying the quality data produced on consultants (and hospitals).<sup>179</sup>
- 2.416 AXA PPP and Simplyhealth told us that this remedy was both practicable and an appropriate starting point in terms of consultant information and suggested that if the initiative proved its value, it should be rolled out to a larger list of specialties with different measures included.<sup>180</sup>
- 2.417 Aviva had similar concerns to Bupa, noting that for most procedures patients wanted and needed a broader range of performance measures. For example, a patient considering undergoing knee replacement surgery was likely to be interested primarily in how effective the operation was likely to be in terms of improved mobility and/or reduced pain and would wish to compare consultants on this basis, rather than on the basis of their mortality rates for the surgery. Aviva highlighted the risk that the CC's recommendation might be ignored or might not be implemented in the way envisaged since recommendations were non-binding on the party to which they were addressed.<sup>181</sup>
- 2.418 PruHealth supported the publication of additional consultant performance information but highlighted similar concerns to Bupa around the number of specialties currently included in the NHS England initiative, as well as the appropriateness of the measures selected and the extent to which the format in which they were presented was meaningful to patients. PruHealth suggested that additional quality measures

---

<sup>179</sup> *ibid*, paragraph 6.9.

<sup>180</sup> [AXA PPP response to the Remedies Notice](#), paragraphs 4.4 & 4.5; [Simplyhealth response to the Remedies Notice](#), Remedy 5.

<sup>181</sup> [Aviva response to the Remedies Notice](#), Section 5.



should include: unplanned readmission rates, infection rates, bed sores, rates of deep vein thrombosis and pulmonary embolism and ‘never events’.<sup>182</sup> In addition, PruHealth suggested that patient surveys could also be conducted in a standardized format across all hospitals and published. This information could include ‘functional scores’ (like patient reported outcome measures (PROMs)) or ‘Patient Experience Surveys’.<sup>183</sup>

2.419 PruHealth noted that any process of risk adjusting mortality rates to reflect the co-morbidities of patients would be imperfect and that some distortions to reported outcomes might arise when mortality rates were low and there were few procedures carried out by the consultant in private practice (on which the mortality rates were based).<sup>184</sup>

- *Hospital operators*

2.420 While BMI did not believe that deficiencies in this area were sufficient to establish an AEC, BMI told us that it fully supported the adoption of the proposed Remedy 5 and that it considered it appropriate that the publication of performance data should cover the entirety of a consultant’s practice.

2.421 HCA supported the CC’s proposed recommendation noting that the list of ten specialties was a practical starting point and that this list should be expanded over the coming decade to include all medical and surgical specialties. HCA suggested that UK-wide specialty registries and audits should be developed for all specialties

---

<sup>182</sup> ‘Never events’ are adverse events that are unambiguous (clearly identifiable and measurable), serious (resulting in death or significant disability), and usually preventable if the available measures have been implemented by healthcare providers. [www.cqc.org.uk/organisations-we-regulate/registered-services/information-professionals/never-events](http://www.cqc.org.uk/organisations-we-regulate/registered-services/information-professionals/never-events).

<sup>183</sup> PruHealth response to the Remedies Notice, Section 5.

<sup>184</sup> *ibid*, Section 5.

and that these performance measures should be based on ICD 10 or 11 diagnosis coding and OPCS<sup>185</sup> procedure coding.<sup>186</sup>

2.422 Spire did not make any separate submissions on consultant quality information, expressing support for the Private Hospital Information Network's (PHIN) submissions on Remedy 5 (see paragraphs 2.429 and 2.430 below).<sup>187</sup>

2.423 Nuffield stated that it considered annually updated information on consultant quality should be made available to patients, GPs, and insurers alike.<sup>188</sup>

2.424 Circle fully endorsed our proposed Remedy 5 and suggested that the CC impose a requirement that universal minimum standards were agreed by providers within 12 months.<sup>189</sup>

- *Others*

2.425 The Scottish Government explained that it welcomed the principle of publishing hospital- and consultant-level outcomes data and believed that measuring and reporting outcomes data for specific conditions and procedures was an essential tool to better understand and improve patient care. It currently encouraged the submission of data to relevant audits and supported the publication of data to increase transparency and drive improvement. The Scottish Government planned to facilitate wider Scottish participation in national audits and expected that these audit figures would be used within boards and teams to discuss quality of care. It told us that a work programme was underway to ensure a clear focus on the collection of clinical data for quality improvement in Scotland in the future. This would include

---

<sup>185</sup> Office of Population and Censuses and Surveys Classification of Interventions and Procedures coding.

<sup>186</sup> [HCA response to the Remedies Notice](#), Section 10.

<sup>187</sup> [Spire response to the Remedies Notice](#), paragraph 9.1

<sup>188</sup> [Nuffield response to the Remedies Notice](#), paragraphs 6.1 & 6.2.

<sup>189</sup> [Circle response to the Remedies Notice](#), remedies 5, 6 and 7.

consideration of how best to use the current national audits as effectively as possible to drive improvement and provide robust and appropriate information to clinicians, NHS boards and the public.

2.426 The Department of Health, Social Services and Public Safety in Northern Ireland told us that it currently had no plans to publish performance data for individual consultants, although it noted that performance data for some consultants may already be picked up in the data published by NHS England.

2.427 The Welsh Government explained that the information on surgical outcomes currently being released by NHS England was based on data collected in National Clinical Audits managed by the Healthcare Quality Improvement Partnership. Welsh Health Boards and Trusts participated in these audits and as Specialist Societies operated on a UK (or UK & Ireland) basis, performance information for many Welsh surgeons was included within this dataset. The Welsh Health Minister has encouraged other Welsh surgeons to consent to the release of their data.

2.428 However, the Welsh Government stated that, with the development of multi-disciplinary team working, it believed that successful patient outcomes depend upon more than just the surgeon. It highlighted that Wales was committed to improving the information available to patients, and with this in mind was in the process of developing a website 'My Local Health Service'.<sup>190</sup> Information on the outcomes of care would be published on this website which would support patients in making fully informed consent. As part of this process, the Welsh Government had plans to

---

<sup>190</sup> <http://mylocalhealthservice.wales.gov.uk/#/en>.

publish hospital level data for specialist areas over the next six months,<sup>191</sup> and will investigate further the possibility and value of providing individual surgeons' data.

2.429 PHIN expressed concern that the CC had overstated the extent to which the registry datasets<sup>192</sup> were sufficient to constitute adequate information for patients on consultant quality. As regards the consultant data published by the NHS, PHIN noted that:<sup>193</sup>

- (a) it was not presented in a format that was meaningful for patients;
- (b) it did not provide enough information on a consultant's practice to allow patients to make meaningful choices between consultants. For example, PHIN suggested that patient feedback on consultants should be collected;
- (c) it did not cover all specialties; and
- (d) several of the databases did not currently cover consultants' private practices.

2.430 PHIN suggested that a solution in terms of consultant performance information would have to come from within the private healthcare sector and offered to support any initiatives to the extent possible. PHIN noted that it was currently in the process of collating data on consultant activity in both the NHS and private sectors, which it planned to provide to consultants over 2014 to support them in the new General Medical Council (GMC) revalidation procedure.<sup>194</sup> The type of information being collected by PHIN is set out in Figure 2. PHIN suggested that this dataset could eventually be used to provide information on consultant performance, although there were a number of data issues to resolve first which would require input from consultants and their professional bodies.<sup>195</sup>

---

<sup>191</sup> Submission from the Welsh Government to the CC, 4 December 2013.

<sup>192</sup> This is the information published by NHS England on consultant performance.

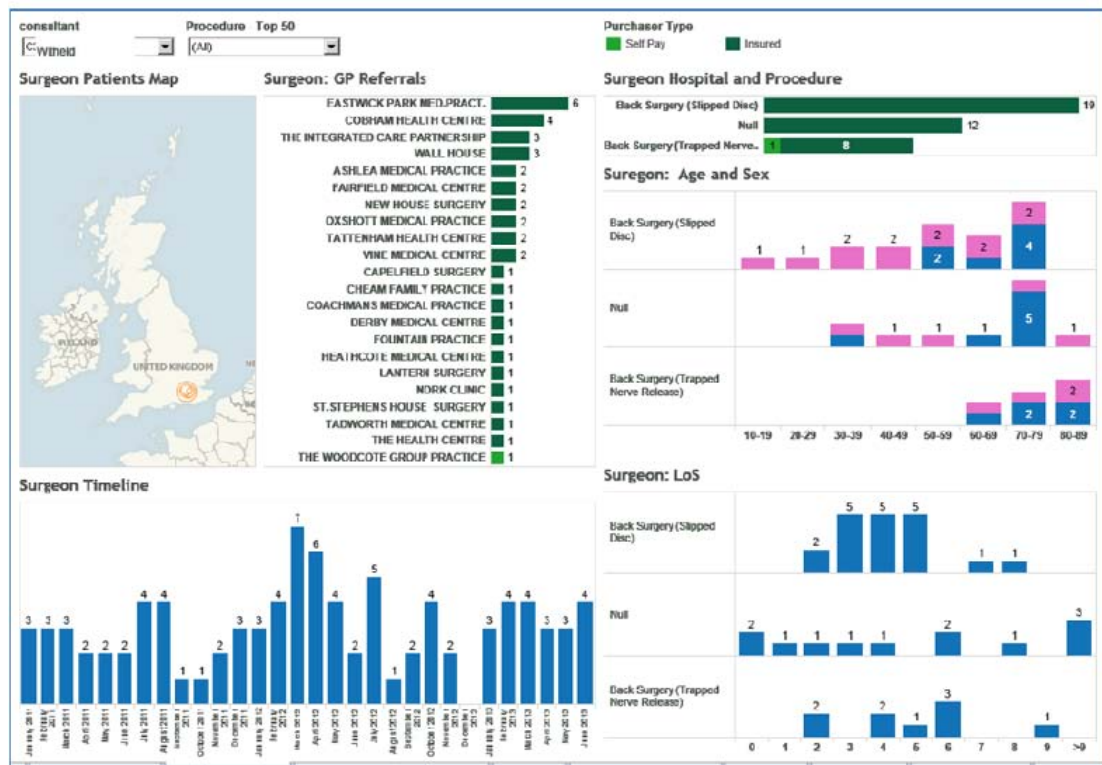
<sup>193</sup> [PHIN response to the Remedies Notice](#), Remedy 5.

<sup>194</sup> [www.gmc-uk.org/doctors/revalidation.asp](http://www.gmc-uk.org/doctors/revalidation.asp).

<sup>195</sup> [Summary of hearing with PHIN](#), paragraphs 21–24.

FIGURE 2

### Exemplar consultant activity dashboard (PHIN)



Source: PHIN presentation to the CC, 6 November 2013.

2.431 The Federation of Independent Practitioner Organisations (FIPO) told us that it was cooperating with PHIN in its initiative to collect consultant activity data. FIPO agreed with PHIN's view that in order to produce meaningful data on consultant performance, it would be necessary to engage extensively with consultants and their professional and representative bodies. Furthermore, FIPO suggested that the (activity) information collected should not be published at the outset but should initially be used as a tool to help consultants understand and examine their practice in order to establish trust and credibility in the process.<sup>196</sup>

2.432 The Association of Anaesthetists of Great Britain and Ireland (AAGBI) noted that our proposed Remedy 5 relied heavily on the performance data published by NHS

<sup>196</sup> FIPO response to the Remedies Notice, paragraph 5.13 and FIPO letter to the CC, 28 October 2013.

England. However, it expressed concern that this data was only relevant to ten specialities and, although the data might be risk-adjusted, it would be very difficult for patients to interpret. The AAGBI suggested that the CC, the PMIs, the PHPs and the relevant specialty representatives worked together to provide a realistic and readily interpretable dataset of consultant performance for all specialities, and offered to support this initiative in so far as it related to anaesthetists.<sup>197</sup>

### *Private hospital performance information*

2.433 Remedy 7 in the Remedies Notice addressed the lack of information available to patients on hospital performance. Remedy 7 proposed that the CC would require that all private acute hospitals in the UK collect HES equivalent and PROMs data for private patients and that appropriate arrangements are made for its publication to consumers.

### *How the proposed Remedy 7 may have addressed the AEC*

2.434 In the Remedies Notice we considered that the proposed Remedy 7 would address the AEC identified in our provisional findings by increasing the information on hospital performance or quality that is available to patients, enabling them to make meaningful choices between hospitals. By improving the availability of suitable information, Remedy 7 should stimulate competition between private hospitals on the basis of the quality of service they provide.<sup>198</sup> In this case, our initial proposal was to require private healthcare providers to collect and publish quality information that was at least equivalent to that available to NHS patients.

---

<sup>197</sup> [AAGBI response to the Remedies Notice](#), Remedy 5.

<sup>198</sup> We note that there are several means by which this competition may be stimulated, including by the involvement of PMIs which may choose to take a differential approach to recognition, reimbursement and/or the direction of patients towards/away from consultants according to their performance.

## Background

2.435 The NHS Choices website provides patients with a range of hospital-level (Figure 3) and procedure-specific (Figure 4) performance measures on NHS hospitals to aid patient choice. The information provided includes user ratings, the level of recommendation by both staff and previous patients, whether the facility meets Care Quality Commission (CQC) standards, the number of procedures carried out, the average length of stay, the mortality rate, the rate of unplanned readmissions, the rate of surgical site infections and the average waiting time for the procedure. In addition, information is collected and made available on PROMs,<sup>199</sup> including clinical complications post-surgery.<sup>200</sup> This data is based on Hospital Episode Statistics (HES) and patient surveys, collected by both NHS and private hospitals (for NHS-funded patients).

FIGURE 3

### Hospital-level performance measures (NHS Choices)

Topics	Key Facts	NHS Choices users rating	Recommended by staff	Friends and Family Test score: Inpatient	Responding to patient safety alerts	Mortality rate	Care Quality Commission national standards
Sort by	Nearest						
<b>Update results</b>							
<b>St Pancras Hospital</b> <span>Add to shortlist</span>							
Inpatient Unit South Wing 4 St Pancras Way London Greater London NW1 0PE 1.16 miles away   <a href="#">Get directions</a>		 1 rating <a href="#">Rate it yourself</a>	66 % of staff who would recommend this organisation	n/a Data not available	 Good - All alerts signed off where deadline has passed	n/a Data not available	n/a Data not available
<b>Royal National Throat, Nose and Ear Hospital</b> <span>Add to shortlist</span>							
Tel: 020 3456 7890 330 Grays Inn Road London WC1X 8DA 1.44 miles away   <a href="#">Get directions</a>		 25 ratings <a href="#">Rate it yourself</a>	83 % of staff who would recommend this organisation	 In the normal range (score: 81 from 57 responses) <a href="#">More detail</a>	 Poor - Some alerts not signed off after deadline	 Better than expected in hospital and up to 30 days after discharge (0.7081)	 All standards met <b>Visit CQC profile</b>

Source: NHS Choices website.

<sup>199</sup> <https://catalogue.ic.nhs.uk/publications/hospital/proms/proms-eng-apr-11-mar-12-final/final-proms-eng-apr11-mar12-scor-comp.xlsx>.

<sup>200</sup> <https://catalogue.ic.nhs.uk/publications/hospital/proms/prom-spec-topi-com-after-surgery-2010-11/proms-eng-apr10-mar11-toi-comp-aft-surg-face.xlsx>.

FIGURE 4

### Procedure-level performance measures (NHS Choices)

Topics Key Facts	NHS Choices users rating	Number of operations	How long people stayed in hospital	Mortality rate for hip replacements	Average time from referral by GP to treatment for this department	Rate of unplanned readmissions to hospital	Levels of surgical site infections
Sort by Nearest Update results							
<b>The Whittington Hospital</b> <span>Add to shortlist</span>							
<b>Tel: 020 7272 3070</b> Magdala Avenue Magdala Avenue London N19 5NF 1.49 miles away   <a href="#">Get directions</a> 	 63 ratings <a href="#">Rate it yourself</a>	<b>135</b> Hip replacement procedures	<b>6.0</b> days	 Too few cases to calculate ( )	<b>9</b> weeks	 Average with a rate of 8.4	 Average with a rate of 2.9%
<b>University College Hospital</b> <span>Add to shortlist</span>							
<b>Tel: 020 3456 7890</b> University College Hospital 235 Euston Road London NW1 2BU 1.95 miles away   <a href="#">Get directions</a> 	 86 ratings <a href="#">Rate it yourself</a>	<b>216</b> Hip replacement procedures	<b>8.0</b> days	 As expected ( 0.0 )	<b>10</b> weeks	 Average with a rate of 5.3	 Average with a rate of 0.6%

Source: NHS Choices website.

2.436 In addition, organizations such as Dr Foster also produce reports that seek to rank NHS hospitals on the basis of their performance outcomes and their efficiency, although this information is not necessarily produced in a format that facilitates decision-making by patients.<sup>201</sup>

#### *What the parties told us*

- *PMIs*

2.437 Bupa supported the proposed Remedy 7 but noted that it might not provide a comprehensive solution to the lack of hospital information without additional information. In particular, Bupa highlighted the limited scope of NHS PROMs data, which covered only four procedures;<sup>202</sup> the need for the remedy to be dynamic, ensuring that the private sector maintained parity with the NHS in the future as NHS

<sup>201</sup> See: [www.drfoosterhealth.co.uk/](http://www.drfoosterhealth.co.uk/).

<sup>202</sup> These are: hip replacements, knee replacements, groin hernias and varicose veins.



information evolved; and the need for private hospitals to report basic patient safety measures. Bupa's proposals to strengthen this remedy were:<sup>203</sup>

- (a) to expand PROMs across a wider list of specialisms, establish a committed timetable for implementation and ensure that it maintains at least parity with the NHS in the future as the PROMs dataset evolved;
- (b) the standardization of clinical coding using the ICD 10 (impairment/diagnostic) and Clinical Coding & Schedule Development Group (CCSD)<sup>204</sup> (procedure) systems to allow the datasets collected to be helpful in benchmarking performance;
- (c) the inclusion of patients' NHS number in the data collected by private hospitals in order to allow patients' private and NHS treatment pathways to be linked up and to ensure comparability with the NHS across all private healthcare outcome data,<sup>205</sup>
- (d) the mandatory completion of clinical registries by consultants practising privately;
- (e) the prohibition of contract clauses that currently prevent the PMIs from sharing quality data on hospitals with patients; and
- (f) the reporting of 'basic patient safety measures' by private hospitals.

2.438 Bupa highlighted that PMIs needed access to the raw data underlying any quality measures in order to carry out their own analysis, rather than having access to the same outcome measures as patients. Bupa suggested that PHIN was not an appropriate organization for this task as it was controlled by the private hospitals, could not compel hospital groups to provide data, did not have a means to check the data provided and did not have committed funding budgets. Instead, Bupa proposed that either the NHS Information Centre (NHSIC) or an independent replacement for

---

<sup>203</sup> [BUPA response to the Remedies Notice](#), paragraph 6.59.

<sup>204</sup> BUPA supported the CCSD system rather than the use of OPCS which it believed was 'not sufficiently precisely described' for billing purposes.

<sup>205</sup> For example, where a patient has an operation in a private hospital but then is readmitted to an NHS hospital due to a complication, at the moment the private hospital will not necessarily be aware of this and will not include this readmission in its performance statistics. With an NHS identifier, the whole patient journey can be mapped, making performance measures more reliable.

PHIN should hold this data and the private hospitals be compelled to provide it with the data. Whichever organization was used, Bupa suggested that there should be an agreed plan and a set of milestones.<sup>206</sup>

2.439 AXA PPP supported the collection of HES-equivalent and PROMs data by the private hospitals and believed that this could reasonably be mandated within a two-year time frame. However, AXA PPP did not see value in the use of ICD 10 coding due to concerns over the accuracy of the data and the costs of collecting it, with the former issue calling into question the ultimate usefulness of the information to patients and PMIs.<sup>207</sup>

2.440 PruHealth was supportive of a remedy to require private hospitals to collect and report HES data and suggested that the CC should require this within a 6- to 12-month time frame from publication of our final report. In addition, PruHealth suggested that the private hospitals be required to use ICD 10 coding in order to facilitate both the analysis of performance and the identification of over-utilization/inappropriate therapies in a fee-for-service reimbursement model.<sup>208</sup>

2.441 Aviva noted that whilst the CC's proposals in terms of hospital information were positive, they were also limited and put forward the view that cross-industry participation was required to determine exactly what information should be collected and how it should be presented: 'Any information remedy imposed by the CC will need to be flexible enough to allow for changes in the availability of healthcare information in the future driven by technological changes. Any attempt to limit exactly what is required at the current point in time will stifle future improvement.' Aviva was also concerned that the information provided to patients be in a format that they were

---

<sup>206</sup> [BUPA response to the Remedies Notice](#), paragraphs 6.60–6.62.

<sup>207</sup> [AXA PPP response to the Remedies Notice](#), paragraphs 5.3–5.7.

<sup>208</sup> [PruHealth response to the Remedies Notice](#), Section 7.

able to understand and therefore make meaningful comparisons between hospitals.<sup>209</sup>

2.442 Both Simplyhealth and WPA were supportive of the CC's proposed remedy and suggested that the collection of ICD 10 diagnostic codes would enhance the usefulness of the data collected.<sup>210</sup>

- *Hospital operators*

2.443 While BMI did not believe that deficiencies in this area were sufficient to establish an AEC, BMI told us that it recognized the need to make available to patients easily comparable information relating to hospital quality and therefore fully supported the CC's proposals requiring private hospitals to publish data equivalent to that provided by the NHS. BMI further argued that the remedy was practicable, could be achieved within a 12-month time frame, that PHIN was the most appropriate body to perform this role for the industry and that the initiative should be funded by all participants in the industry and not just the private hospital operators.

2.444 HCA told us that it would be both desirable and practicable to require within a reasonable time period that private hospitals collect NHS HES and PROMs data and put into place systems to collect ICD 10 or 11 coding, as well as systems to code procedures using the OPCS 4.6 system instead of (or as well as) CCSD codes. HCA suggested that the CC should seek a five-year voluntary agreement from the Association of Independent Healthcare Organisations (AIHO) that PHIN retained sufficient funding to continue to develop its activities over the next five years.<sup>211</sup> HCA told us that specific hospital operators had not yet committed to PHIN and called

---

<sup>209</sup> [Aviva response to the Remedies Notice](#), Section 7.

<sup>210</sup> [Simplyhealth response to the Remedies Notice](#), Remedy 7.

<sup>211</sup> [HCA response to the Remedies Notice](#), Section 12.

upon those hospitals operators to do so and sought help from the CC to achieve this.<sup>212</sup>

2.445 Spire did not make any separate submissions on hospital quality information, expressing support for PHIN's submissions on the proposed Remedy 7 (see paragraphs 2.449 to 2.452 below).<sup>213</sup>

2.446 Nuffield supported the collection and publication of further information on the performance of private hospitals but considered that the HES system was not a suitable format for this information and would increase costs for patients due to the burden on hospitals collecting this data: 'PROMs, on the other hand, is both easy to collect and a helpful source of information'.<sup>214</sup> Nuffield suggested that for any particular facility, a simple dashboard by procedure that indicated pictorially a number of key metrics might prove more useful than a large number of numerical indicators. Such a dashboard might display whether:

- (a) sufficient volumes were performed to maintain operator competencies;
- (b) infection levels met best practice standards;
- (c) outcomes exceeded or were in line with national averages;
- (d) patient satisfaction scores were at excellent levels; and
- (e) parking and other named facilities were available.

2.447 TLC supported publication of information on private hospital performance and patient outcomes, putting forward the view that this would act as a spur to increased competition and better decision-making by PMIs and patients. TLC told us that it would support the collection and suitable publication of HES-equivalent and PROMS

---

<sup>212</sup> [HCA response to the Remedies Notice](#), Section 12(e).

<sup>213</sup> [Spire response to the Remedies Notice](#).

<sup>214</sup> [Nuffield response to the Remedies Notice](#), paragraphs 8.1–8.4.

data provided that the process was independent, proportionate and operated fairly for smaller or single-site hospitals as well as the large hospital groups.<sup>215</sup>

- *Others*

2.448 PHIN told us that it was currently collecting data from 194 private hospitals in the UK that was approaching HES-equivalency and that the greatest remaining obstacle to full equivalency was the lack of diagnostic coding in the data set. Diagnostic codes record the patient's medical condition, its severity, and any co-morbidities, such as diabetes. By applying a diagnostic code to each patient episode, PHIN told us that it would be able to risk-adjust performance measures, ensuring that like-for-like comparisons were made.<sup>216</sup>

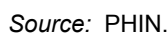
2.449 PHIN set out its current timetable for the publication of performance/quality information on private hospitals (see Figure 5), although it highlighted that in many cases it was reliant on support or cooperation from external (often government) bodies in order to meet many of its deadlines.

---

<sup>215</sup> [TLC response to the Remedies Notice](#), paragraphs 28 & 29.

<sup>216</sup> For example, mortality rates for an operation are likely to be higher among patients with significant co-morbidities as compared with those that are otherwise healthy. In order to compare the performance of hospitals (or consultants) accurately, it is necessary to control for the condition of their patients. ([PHIN response to the Remedies Notice](#), Remedy 7.)

## PHIN timeline for publication of private hospital performance information



2.451 PHIN also argued that the CC should take into account the need to balance the costs associated with collecting certain information against the benefits derived by patients

218 PHIN response to the Remedies Notice, Remedy 7.

using that information. In this context, PHIN suggested that PROMs data was of clear benefit in the context of hip and knee replacements and was probably useful for hernia patients but that it may be of limited use for varicose vein patients.<sup>219</sup>

2.452 In addition to introducing diagnostic coding, PHIN argued that the industry should move away from CCSD coding towards OPCS coding in order to ensure comparability between NHS and private datasets and to facilitate the checking of datasets by the providers of the information, whether hospitals or consultants.<sup>220</sup>

2.453 FIPO argued that, in order to make the remedy comprehensive, the CC should mandate the routine collection of diagnosis, co-morbidity, complications and procedure codes, using ICD 10 and OPCS standards. In addition, FIPO noted that the remedy did not address the information asymmetries between patients and their PMIs, expressing concern that Bupa was providing patients with medical advice (via its Treatment Options Service) that in FIPO's opinion it was not qualified to do and which might result in harm to patients.<sup>221</sup>

2.454 The AAGBI suggested that the proposed Remedy 7 was practicable and should be applied to all private hospitals, noting that it should be based on ICD 10 coding, with the CCSD coding system being abandoned. The AAGBI expressed a number of reservations about PROMs data on the grounds that patients were not necessarily able to discriminate reliably between good and bad clinicians but might be swayed by more subjective issues such as the quality of communication from the consultant rather than more objective clinical outcomes.<sup>222</sup>

---

<sup>219</sup> PHIN response to the Remedies Notice, Remedy 7.

<sup>220</sup> Summary of hearing with PHIN, paragraph 19.

<sup>221</sup> FIPO response to the Remedies Notice, paragraphs 5.5–5.18.

<sup>222</sup> AAGBI response to the Remedies Notice, Remedy 7.

2.455 CCSD put it to the CC that by mandating the use of OPCS rather than CCSD codes, the CC would create significant complexity and transition costs for the sector without improving the transparency of information. In particular, CCSD argued that:<sup>223</sup>

- (a) OPCS was not designed to be used for payments or billing and hence contained codes that were unnecessary from a commercial point of view as well as vague codes, such as ‘unspecified’;
- (b) OPCS was only updated only once a year, which was too infrequent to accommodate fair payment for emerging treatments; and
- (c) OPCS was based on NHS activity and therefore might not cover all activity covered by private medical insurance.

2.456 In contrast, CCSD argued that its coding system was designed for PMI commercial use, updated monthly based on the introduction of new treatments into PMI, and enabled separate payments to hospitals and healthcare professionals.

### *Assessment of performance information remedies*

2.457 We now examine aspects of the design of this remedy before concluding on its effectiveness and proportionality.

#### *Design considerations*

2.458 In order for this remedy to be effective, ie for patients to make meaningful choices between consultants and hospitals based on quality, we reasoned that they and their representatives<sup>224</sup> would need to have access to information that was relevant, accurate, comparable, and easy to understand. This means, inter alia, that:

- (a) performance measures published should be those most relevant for patients in making their choice. These are likely to vary according to the type of procedure and the preferences of the patient;

---

<sup>223</sup> [CCSD response to the Remedies Notice](#).

<sup>224</sup> In this context, patients’ representatives include their GPs, consultants and, where relevant, PMIs.



- (b) the same information should be collected on all hospitals or consultants with private practice in a given specialty, with raw data risk-adjusted where appropriate to ensure like-for-like comparisons;
- (c) there should be a sufficient but not excessive range of performance measures published to allow patients to make comparisons on several bases, whilst avoiding 'information-overload';
- (d) data should be presented in a format that allows patients to *compare* the performance of two (or more) consultants or hospitals easily, with graphics used to enhance understanding of the data and comparability; and
- (e) data should be available to all interested parties to scrutinize, evaluate and critique to ensure that it is robust and seen to be robust by all industry participants, hospitals, consultants, insurers and patients. Such confidence in the data is essential to its usefulness for all parties.

2.459 The remedy would not be effective if the information provided was irrelevant, could not be compared, was insufficient, or was presented to patients in a format that they could not easily understand. Having considered the responses received, we have come to the conclusion that our Remedy 5, as initially designed, would be ineffective in addressing the AEC arising from a lack of information on consultant performance. In particular, we note the limited range of treatments covered, the limited performance measures included, which often do not distinguish between consultants based on performance, and the format in which the data is presented, which is likely to make it difficult for patients to interpret correctly. We note that this data may be of some, limited use to GPs in determining to whom to refer patients but we do not consider that the ability of GPs to interpret the data for patients resolves the first two of our concerns satisfactorily.

- 2.460 Although there are plans to increase the quantity of data available in England and, to a (potentially) more limited extent, in the other nations of the UK, we do not consider that this increased information is likely to substantially rectify the limitations we have identified in the foreseeable future.
- 2.461 In contrast, we considered that our proposal for the provision of additional hospital performance information would be effective subject to some additional informational requirements.
- 2.462 The submissions that we have received indicate that it is possible to provide consultant-level performance data using the same datasets that are already being collected to provide information on hospital quality, provided that patient episode data is augmented with the GMC number of the treating consultant.
- 2.463 We propose, therefore, to address both consultant and hospital quality via a single remedy which requires private hospital operators to provide information in an appropriate format to a suitable information organization for publication to patients. A suitable organization for these purposes will be one with the ability to design meaningful performance measures in collaboration with industry participants, collect and analyse patient episode statistics and publish outcome measures in a format that is easy for patients to understand according to the timetable set out by the CC.<sup>225</sup> It will need to be independent of the private hospital operators, insurers and consultants but able to work with these parties to ensure that meaningful information is provided to patients. We consider that PHIN, with an expanded membership base, is likely to be a suitable information organization for these purposes (see paragraphs 2.470 to 2.475 below).

---

<sup>225</sup> The CC previously mandated the provision of additional information via a third party organization in the Home Credit market inquiry. This took the form of a price and terms comparison website.

### *Information requirements*

- 2.464 As regards the provision of hospital and consultant quality information, we have sought to balance the information needs of patients and the feasibility (and costs) of substantially increasing the availability of performance information. We note that the challenge of providing relevant, accurate and comparable data on both hospital and consultant performance is significant, with the NHS in England only recently starting to publishing limited data in this respect. Therefore, we reasoned that it would be necessary to allow a reasonable timetable for this organization to develop and publish appropriate quality measures.
- 2.465 We will require all private hospital operators<sup>226</sup> with UK turnover of £5 million or more to collect and submit patient episode data for all patients treated at its facilities, whether inpatient, day-case or outpatient,<sup>227</sup> to a suitable information organization from which the latter can derive the following types of performance measures at both the hospital and consultant level:
- (a) volumes of procedures undertaken;
  - (b) average lengths of stay;
  - (c) infection rates, surgical and hospital-acquired;
  - (d) readmission rates;
  - (e) revision rates (where appropriate);
  - (f) information on the frequency of adverse events, such as post-operative DVT and cardiac arrest (where appropriate);
  - (g) relevant information from clinical registries and audits as appropriate and where available;

---

<sup>226</sup> This should include all hospitals and clinics providing secondary medical or surgical treatments to patients within the UK, including NHS PPUs and specialist clinics. Our market investigation has not focused on treatments such as cosmetic surgery, hence we do not envisage that clinics specializing in such treatments would be included in this remedy. However, we would encourage the Information Organization to seek information from such clinics and to publish it alongside the other information.

<sup>227</sup> We envisage that this would include all patients receiving treatment of any kind, including diagnostic scans and tests but exclude those attending a facility for a consultation only.

- (h) for the ten highest-volume, or otherwise most relevant, procedures, a procedure-specific measure of improvement in health outcome;<sup>228</sup> and
- (i) a measure of patient feedback and/or satisfaction on the service provided.

2.466 In order to facilitate the analysis and publication of meaningful performance statistics, we would expect the data submitted by the private hospital operators to the information organization to:

- (a) include the GMC number of the consultant responsible for each patient episode occurring in the operators' facilities;
- (b) include the NHS number of patients or alternative information from which patients' NHS numbers can be derived;
- (c) contain diagnostic coding<sup>229</sup> for each episode in order to allow for risk-adjustment where appropriate;
- (d) be fully comparable with that collected by the NHS to allow the information organization to report performance measures for the whole of consultants' practices, both NHS and private, since this is the relevant basis on which to judge performance;
- (e) be made available to the information organization in stages, with all the above information submitted by September 2016 to facilitate the publication of these measures over the next three years, with all data made available to the public from April 2017 onwards; and
- (f) be made available with suitable data security provisions in a 'raw' format to all relevant interested parties, including the private hospital operators, consultants, insurers, the CQC, Dr Foster and HSCIC from April 2017 onwards.

---

<sup>228</sup> The most relevant procedures may not be synonymous with the most common but we would expect a reasonably high level of overlap. A procedure-specific measure of improvement in health outcome might be, for example, the improvement in vision enjoyed by a patient following cataract surgery, or the reduction in pain and increase in mobility following rotator cuff repair surgery. We note that PHIN is currently exploring how it could introduce a PROMs measure for cataract procedures and it told us that other procedures which might be suitable for later inclusion based on volume and tangible benefit could possibly include: cardiac procedures (cardiology), hysterectomy (gynaecology), laminectomy (spinal surgery), laparoscopic cholecystectomy (general surgery), TURP (urology), and breast reconstruction (plastic surgery).

<sup>229</sup> An appropriate diagnostic coding system should be an internationally recognized standard such as ICD 10 coding. We would expect the information organization to agree this with the private hospital operators.

2.467 We have taken account of the disagreement between some of the insurers and the private hospital operators (and PHIN) with respect to the type of procedure coding that should be used. We were told that the private hospitals currently use OPCS coding for their NHS patients and CCSD coding for private patients.<sup>230</sup> While we thought that it would be preferable for a single system of coding to be used across the whole healthcare sector since this would lower processing costs, we recognize that the conversion of IT and billing systems is also a potentially costly and time-consuming process. We thought, therefore, that over the next five years the private hospital operators could provide both an OPCS and a CCSD code on their invoices to Healthcode, with the insurers using the latter and the information organization using the former. However, given that greater information availability is beneficial to the sector as a whole and that the comparability of the data across both the NHS and the private sector is important to gain a full understanding of quality and performance, in the longer run, we reasoned that the private system would need to come in line with the NHS in terms of its coding protocols. Therefore, by April 2019, we will require the insurers to adapt their IT and billing systems to use OPCS coding, allowing the private hospitals to submit invoices with a single procedure code. We believe that this five-year transition period will allow the insurers to make the appropriate changes without incurring undue costs, as well as minimizing the longer-term costs to the private hospital operators of providing performance information.

2.468 In order to facilitate the dissemination of quality information to patients, we will require that the PMIs include standard wording in the correspondence sent to customers on taking out or renewing a private medical insurance policy informing them that they will be able to obtain quality information on consultants and hospitals from the website of the information organization. In addition, patients should be

---

<sup>230</sup> [Summary of hearing with PHIN](#), paragraph 20.

directed to this website when they call to obtain pre-authorization for treatment and whenever advising a policyholder on potential providers.

2.469 We consider that the provision of quality information as set out above represents a minimum level that patients require in order to make informed choices between hospitals and consultants. However, the provision of additional information, such as cancer survival rates, would enhance the ability of patients to make meaningful choices between providers. Therefore, we will require a review of this remedy by the CMA five years after its implementation to consider whether the information requirements have been met and whether further information is needed by patients to facilitate effective competition.

#### *Information organization*

2.470 We next considered how a suitable information organization would need to be structured in order to function effectively. We thought that it would need to be:

- (a) independent of the private hospital operators, insurers and consultants but be able to work with them, taking their views and legitimate interests into account when reaching decisions on what information should be collected, how it should be processed and the format in which it should be published;
- (b) transparent to all industry participants in terms of its methods and analysis of the data provided by the private hospital operators; and
- (c) funded and resourced to ensure that it has the strategic and technical skills to deliver high quality performance measures within the timelines set out in paragraph 2.466.

2.471 In order to meet these requirements, we thought that the information organization would need to have an inclusive membership base, comprising the private hospital operators that submit data to it, the PMIs active in the UK market and consultant

representatives.<sup>231</sup> The organization would need to have a strong independent management board comprising both non-executive and executive members, headed by an independent chair. The members of the management board should have significant expertise in the healthcare sector with at least one non-executive member representing the interests of consumers as patients will not be members of the organization itself. In addition, we thought that two of the non-executive members of the board should be nominated by the CMA and that it may be necessary for certain issues to be reserved to these members to ensure the smooth-running of the information organization.<sup>232</sup> We invite parties to make submissions regarding which issues may need to be reserved to CMA-nominated board members and how member organizations should be represented within the information organization.

2.472 The executive members should have particular expertise in the issues of collecting and analysing quality/performance information in a healthcare context. We thought that the Chair should nominate new board members, with the information organization's members voting to confirm or reject the nominee.<sup>233</sup>

2.473 In order to ensure transparency to its members, we thought that the information organization should draw up a five-year plan setting out the information that it intends to collect, analyse and publish, together with an initial budget to support this plan. It should consult with its members on the plan, incorporating their concerns as appropriate, before submitting the plan to the CMA for approval. In subsequent years, the information organization should publish an annual report, reporting its progress against its original plan, setting out a summary of its activities for the past year, as well as a reasonable level of financial information for members to

---

<sup>231</sup> We envisage that these may be drawn from the consultants' professional bodies, such as the Royal College of Surgeons or the Association of Anaesthetists of Great Britain and Ireland. We thought that all insurers covering 5,000 lives or more in the UK should be required to become members of the information organization.

<sup>232</sup> We envisage that the role of these board members would be to prevent the information organization from becoming gridlocked where member organizations or other board members disagree.

<sup>233</sup> The Chairman could be nominated by members of the information organization and approved by the CMA.

understand how their funds have been used. The annual report should also set out the corporate strategy (targets) of the information organization for the following year. In addition, the information organization should publish its board minutes.

2.474 We thought that PHIN currently demonstrated a number of these features and that, if its membership base and funding sources were adapted, it would be likely to represent a suitable information organization.

2.475 We consider that the costs of funding the information organization should be met jointly and equally by the private hospital operators and the PMIs in proportion to the number of patients they treat or represent (respectively). PHIN told us that its current level of funding would be sufficient to meet its timetable for the collection and publication of the hospital-level quality information set out above. However, we consider that some additional funding may be required to support the development, collection and publication of consultant-level quality information.

### *Conclusions on effectiveness*

2.476 At the moment, private healthcare patients do not have access to sufficient information on the quality/performance of private hospitals or consultants in order to make meaningful choices between them when selecting a provider. This remedy aims to ensure that such information is provided, whilst recognizing that the collection and publication of performance information is a highly complex and relatively new initiative in the UK context.

2.477 In response to our Remedies Notice, a number of parties told us that our initial proposal regarding consultant quality information would not provide sufficient information, in a suitable format for a non-expert audience, to be effective in facilitating patient choice. We consider that by providing the consultant performance



measures set out above on all consultants with a private practice, this remedy will allow patients to make at least some meaningful quality comparisons across all consultants. In addition, for patients undergoing the most common ten procedures, the procedure-specific improvement in health outcome measures would provide substantial benefits in choosing a consultant.

2.478 We consider that the hospital-level data set out above would, likewise, facilitate patients in choosing between facilities based on objective measures of quality.

2.479 In assessing the likely effectiveness of these remedies, we considered whether patients would use the data provided. Our survey indicated that 36 per cent of patients did discuss the clinical expertise of consultants with their GP,<sup>234</sup> with 29 per cent reporting that 'quality of care' was one of the most important reasons for choosing a particular hospital.<sup>235</sup> We believe that this demonstrates that at least a large minority of patients are interested in acquiring information on consultants' expertise and that they are making use of some of the few sources of information currently available. We would expect these patients to use independent quality information if it were available to them. In addition, by requiring the PMIs to inform patients of a new source of quality information, we would expect a larger proportion of patients to look for and use this data in making choices.

2.480 Even in the case where this information was not directly used by patients and the latter continued to rely on the advice of their GPs, we would expect GPs to make use of this additional information when advising patients. Our survey indicated that 81 (56) per cent of GPs felt that clinical expertise was the most important reason for recommending a particular consultant (hospital), and 26 (34) per cent of GPs

---

<sup>234</sup> 39 per cent reported that they had discussed the reputation of the consultant with the GP, which is likely to be closely linked to clinical expertise.

<sup>235</sup> Other factors cited by patients as being important in choosing which hospital included: the clinical expertise of staff (22 per cent) and the facility's clinical outcomes (17 per cent).

reported that they would like additional information on consultant expertise (hospital clinical outcomes).

2.481 In addition, Bupa told us that patients were not the only or even the main users of information and that quality improvements could also be driven by scrutiny by organizations such as the CQC and the GMC, as well as by GPs and PMIs who would advise patients as to which consultants or hospitals to visit.<sup>236</sup> We agree with this view and believe that raw data on performance measures for both hospitals and consultants should be made available to these organizations. However, we also note the concerns expressed by FIPO and numerous consultants that the interests of the PMIs are not necessarily aligned with those of patients. Therefore, we believe that it is appropriate for an independent organization to collect, analyse and publish this data and that this should be the primary data source to which patients should be referred.

2.482 Finally, we note the argument that transparency over outcomes at both the consultant and the hospital level can improve quality due to consultants and hospital operators becoming aware of better and worse practice and seeking to improve their position relative to their peers. Although our remedy is focused on providing patients with the information they need to make meaningful choices, we consider that this type of quality competition can yield significant benefits for patients and is reasonably likely to be a channel through which this remedy has effect. The publication, comparison and analysis of further information on healthcare outcomes allows for the identification of more and less efficient treatment pathways, stimulating competition on the whole value proposition offered to patients, ie information that health outcomes are better using one treatment pathway rather than another should stimulate a change in practice among consultants. Similarly, PruHealth told us that

---

<sup>236</sup> [BUPA response to the Remedies Notice](#), paragraph 6.9.

the combination of diagnostic and treatment coding for each patient, together with outcome data, would allow it to identify which hospitals were providing better value, or more efficient care in terms of achieving the same healthcare outcomes at lower cost. PruHealth suggested that this type of information would allow it to challenge hospitals and/or consultants on an informed basis with regard to the effectiveness and efficiency of their treatment choices. We consider that this type of information should, therefore, allow PMIs to stimulate competition between healthcare providers on the value they offer, with benefits in terms of improvements in quality and reductions in price for patients.<sup>237</sup>

### *Proportionality*

2.483 We set out in paragraphs 2.476 to 2.482 the reasons we consider that this information remedy will be effective in achieving its aim. In this section, we consider the likely costs and benefits of the remedy before coming to a view as to whether it represents a reasonable and proportionate means of achieving its aim.

2.484 The provision of quality information on hospitals and consultants is designed to increase competition among these providers for patients on this basis and thereby drive up the quality of healthcare services provided. Given the nature of ‘quality’ which can be demonstrated across a large number of factors, from mortality rates to customer service, it is not possible to provide any robust quantification of the likely effect. However, an example of the scope for improvement is given by The Society for Cardiothoracic Surgery in Great Britain and Ireland which noted that, following the publication of mortality statistics:

The degree of improvement is marked: between 2001 and 2008 the mortality rates decreased from 2.3 per cent to 1.5 per cent for isolated

---

<sup>237</sup> [Summary of hearing with PruHealth](#), paragraphs 1–4 & 29–31.

CABG,<sup>238</sup> 2.6 per cent to 1.7 per cent for all CABG, 5.2 per cent to 3.5 per cent for isolated valves and 8.3 per cent to 6.1 per cent for combined valve & graft operations. All of these improvements are statistically significant.<sup>239</sup>

Even if improvements in outcomes in other specialties were less dramatic, we consider it likely that the potential patient benefits from this remedy are very significant.

2.485 We considered the likely incremental costs of implementing this remedy. At the current time, PHIN receives approximately £1.1 million of funding from the private hospital operators. PHIN told us that funding was not currently a key constraint on delivering the information set out in the timetable in Figure 5. On the assumption that to provide the additional information on hospitals required in our remedy as well as developing the consultant information, a new information organization were to need £2 million funding per year—which we believe would represent an upper end estimate—this represents an incremental cost of just under £1 million per year. In addition, we were told that the costs to the providers of providing an ICD 10 diagnostic code would be around £6.90 per patient.<sup>240</sup> PHIN told us that it currently collected data on 650,000 private patient admissions per year and that it thought this would be likely to increase to around 700,000 with more complete market coverage.<sup>241</sup> On this basis, the incremental cost of ICD 10 coding would be approximately £4.8 million per year.

2.486 Finally, PHIN indicated that the collection and analysis of PROMs style information would cost between £10 and £20 per patient. Assuming that this information were

---

<sup>238</sup> Coronary artery bypass graft.

<sup>239</sup> *Sixth National Adult Cardiac Surgical Database Report, Demonstrating quality, 2008.*

<sup>240</sup> £5.75 plus VAT.

<sup>241</sup> PHIN response to the CC, 13 January 2014.

collected on approximately 15 per cent of private patient episodes, this suggests that the associated costs would be between £1.05 million and £2.1 million per year.

2.487 In addition, we believe that there will be some, relatively minor costs incurred by private hospitals, professional bodies, consultants, PMIs and others in terms of staff time involved in gathering additional performance data, contributing expertise in terms of designing performance measures, checking data and setting up/adjusting IT systems to support this initiative.

2.488 As discussed in paragraph 2.483, it is not possible to provide a robust quantification of the likely improvements in the quality of healthcare services that would result from the greater availability of performance information on hospitals and consultants. However, several previous experiments demonstrated that improvements can be highly significant both in terms of quality and in terms of the cost-effectiveness of services provided. The incremental costs of providing the information set out above are between £6.9 million and £7.9 million per year, which equates to less than 0.2 per cent of the total annual expenditure on private healthcare services.<sup>242</sup>

2.489 Some of the parties suggested that the collection and publication of consultant performance information might discourage consultants from agreeing to treat the most difficult cases. However, we thought that this concern could largely be addressed by risk-adjusting the data (which is facilitated by the collection of diagnostic coding). We note that this is an ongoing process and represents a challenge for the broader healthcare sector as well.

---

<sup>242</sup> Laing & Buisson (2012) indicates that the private-patient-only hospital market was worth £3.54 billion in 2011, whilst total specialists fees were £1.59 billion, giving a total of £5.13 billion. This total is likely to be slightly overstated as the specialists' fees figures may include some fees paid to consultants to treat NHS patients in private facilities.

2.490 We reasoned, therefore, that the likely costs of collecting and disseminating performance information on both consultants and hospitals were relatively low in comparison with the potential quality improvements that could be expected as a direct result of publishing this information. We concluded that our remedy was, therefore, proportionate as a means to address the AEC caused by a lack of quality information in the market for private healthcare services.

### *Information on consultant fees*

#### *Introduction*

2.491 In our provisional findings we identified a lack of information on consultant fees as a feature of the market that gives rise to an AEC in the provision of privately-funded healthcare services:

We identified the lack of sufficient publicly available performance and fee information on consultants as a conduct feature in the provision of privately funded healthcare by consultants. This feature gives rise to an AEC due to the distortion of competition between consultants by preventing patients from exercising effective choice in selecting the consultants by whom to be diagnosed and treated. This reduces competition between consultants on the basis of quality and price.<sup>243</sup>

2.492 In the Remedies Notice, under the proposed Remedy 6 we proposed that (a) all consultants practising in the private healthcare sector be required to publish their initial consultation fees on their websites; (b) each private hospital where they have practising rights would be required to publish these fees on their websites; and (c) we would, further, require consultants to provide a list of proposed charges to patients in writing, in advance of any treatment.

---

<sup>243</sup> [Provisional findings](#), Section 10.

### *How the remedy addresses the AEC*

2.493 The proposed Remedy 6 addresses the AEC identified in our provisional findings by increasing patients' awareness of the fees that they are likely to incur in seeking private treatment, whether covered by insurance or self-pay, and thereby ensure that patients are able to make effective choices between consultants. As a result, when combined with additional information on consultant quality,<sup>244</sup> this remedy will allow patients to choose consultants that offer the best value healthcare, stimulating competition between consultants to attract patients.

### *What the parties told us*

- *Insurers*

2.494 Bupa supported the CC's proposal to require consultants to provide a list of proposed charges to patients in writing in advance of any treatment and suggested that the 'fee quotation document' should:<sup>245</sup>

- (a) be provided as early as reasonably possible in the course of a patient's pathway;<sup>246</sup>
- (b) set out the fees for each part of a consultant's proposed course of treatment, with the CCSD charge code and a clear description of each part;
- (c) where anaesthesia may be required, provide the name and contact details of the anaesthetist and an indicative cost (or at minimum contact details so the patient can contact the anaesthetist themselves in advance); and
- (d) advise patients to check with their insurer in advance of proceeding with treatment.

2.495 Bupa suggested that any change in the scope of treatment should be agreed in a separate document, again provided in advance of treatment. In addition, Bupa

---

<sup>244</sup> This is addressed in Remedy 5.

<sup>245</sup> [BUPA response to the Remedies Notice](#), paragraph 6.40.

<sup>246</sup> BUPA emphasized that patients should be informed of fees at the earliest reasonable time since switching costs increase as the patient moves through the treatment journey.

argued that a document with standardized wording should be sent with the fee quote.<sup>247</sup>

- (a) explaining the patient's rights and the complaints process in the case of a dispute with the consultant;
- (b) explaining how the patient can compare prices if they wish and how the patient can select an alternative consultant;
- (c) explaining where the patient can check consultant quality data; and
- (d) disclosing in writing any relevant conflicts of interest the consultant may have.

2.496 In addition, Bupa recommended that consultants be required to notify their fees to the insurers so that the PMIs are able to relay this information to patients, publish their self-pay outpatient consultation fees and publish their average total costs for their top ten procedures, including initial and follow-up consultation fees, as well as hospital costs and anaesthetist fees. It suggested that the Parliamentary and Healthcare Ombudsman assume responsibility for resolving disputes over consultants' fees.<sup>248</sup>

2.497 Finally, Bupa noted that oncology and other specialties where patients underwent treatment over long periods of time might struggle to provide a 'total' fee estimate in advance. In these cases, Bupa suggested that consultants should provide fee estimates on a monthly/quarterly basis.<sup>249</sup>

2.498 AXA PPP put forward the view that information on all consultant fees and not just outpatient consultations should be made available. In addition, the fee quote should cover other specialist fees, such as those relating to anaesthetists, and be fixed once made, with the consultant assuming the risks associated with complications.<sup>250</sup>

PruHealth, on the other hand, suggested that consultants should state on the fee

---

<sup>247</sup> [BUPA response to the Remedies Notice](#), paragraph 6.40.

<sup>248</sup> *ibid*, paragraphs 6.42, 6.56 & 6.57.

<sup>249</sup> *ibid*, paragraph 6.48.

<sup>250</sup> [AXA PPP response to the Remedies Notice](#), paragraphs 4.9–4.14.



quote that the price excluded any further costs that might result from surgical or unexpected patient complications.

2.499 Aviva told us that it should not be difficult for consultants to provide estimated fees even where unforeseen complications could arise provided that the customer was made aware that added complications might result in the fee being revised.<sup>251</sup>

2.500 PruHealth expressed concerns that the publication of consultant fees, in the absence of accompanying performance or quality information, was likely to result in increases as lower-priced consultants increased their rates in line with higher-priced consultants.<sup>252</sup> Both Bupa and Aviva also had some concerns about this sort of 'race-to-the-top'.<sup>253</sup> PruHealth suggested that the GMC should take responsibility for promoting best commercial practice, monitoring consultant incentives and protecting patients from financial harm, with consultants required to justify fees above a certain level to the GMC.<sup>254</sup>

2.501 For anaesthetists, pathologists and radiologists, who had a limited opportunity to inform patients of fees in advance, PruHealth suggested that the principal practitioner, for example the surgical consultant, should inform the patient of the tariffs and any potential shortfalls from these attending practitioners.<sup>255</sup>

2.502 Simplyhealth suggested that consultants be required to produce and publish a scale (range) of fees that a patient would expect to pay for both an initial consultation and any follow-up consultations and/or treatments. These fee quotes should include anaesthetist fees and the costs of radiology/pathology where relevant. As part of the

---

<sup>251</sup> [Aviva response to the Remedies Notice](#), section 6.

<sup>252</sup> [PruHealth response to the Remedies Notice](#), section 6.

<sup>253</sup> [Aviva response to the Remedies Notice](#), section 6 and Bupa response to the Remedies Notice, paragraph 6.41.

<sup>254</sup> For example, PruHealth suggested that consultants should justify fees which were x% above a published reference price, or those that exceeded 40 per cent of the total hospital cost ([response to the Remedies Notice](#), section 6e).

<sup>255</sup> [PruHealth response to the Remedies Notice](#), section 6d.

fee disclosure statement Simplyhealth would like to see a statement indicating whether the fee quoted excluded any further costs to further aid transparency and enable patients to make informed choices.<sup>256</sup>

2.503 WPA suggested that consultants should provide full details of their fees to patients in advance and submitted a proposed template letter to the CC, setting out how this might be done (see Appendix 2.9). This letter included details of the list price of common diagnostic tests as well as the consultants' fees (both surgeon and anaesthetist) for a range of the most common procedures carried out by the consultant.

- *Private hospital operators*

2.504 Whilst BMI did not believe that deficiencies in this area were sufficient to establish an AEC, BMI fully supported a remedy designed to provide patients with clearer and more comprehensive information on consultant fees and offered to work closely with consultants to ensure that these objectives were achieved. However, BMI highlighted a concern that published information might inadvertently have the effect of misleading patients about the overall (ie including also non-consultant) costs of treatment and suggested that, to avoid this, it would be necessary to make it clear to patients that any fee information provided related to consultant fees only and that hospital fees would be payable in addition. BMI also noted that consultant fees would not necessarily provide a good guide to the level of total fees.

2.505 BMI considered that it should be possible for consultants practising in specialties where procedures were often carried out in an outpatient setting to provide at least a range of costs of any such procedures which might—where clinically appropriate and only with patient consent, both medical and financial—be carried out at an initial

---

<sup>256</sup> [Simplyhealth response to the Remedies Notice](#), Remedy 6.

consultation. BMI noted that guidance on how best to ensure patients received full information on proposed cost, but at the same time were not put to further expense by being required to wait until a subsequent appointment to have a procedure, would be helpful to ensure an appropriate best practice standard was defined. This could include standard wording advising patients to check coverage and any sub-limits within their policy.

2.506 HCA considered that the publication of consultant fees would be practicable for outpatient consultations but would become ‘onerous and cumbersome for day-case and inpatient fees’. HCA suggested that the furthest point in advance it would be practicable to give a proposed fee for a treatment would be once a patient had been fully diagnosed and, even in this case, there would need to be flexibility due to the potential for complications to arise during the treatment pathway. HCA suggested that that a more workable alternative would be for PMIs to introduce ‘erodible benefits’ whereby PMI customers had a total benefit limit up to which they were able to spend at their discretion using the consultants and facilities of their choice and without interference in clinical decisions from PMIs.<sup>257</sup>

2.507 Spire did not make any separate submissions on consultant fee information, expressing support for PHIN’s submissions on our proposed Remedy 6.<sup>258</sup>

2.508 Nuffield noted that its consultants generally performed around five core procedures, with relatively standardized fees for these procedures such that ‘we believe the average fee charged for a consultant’s five most common procedures to be the most appropriate data to publish’. Nuffield suggested that professional bodies, such as the

---

<sup>257</sup> [HCA response to the Remedies Notice](#), section 11.

<sup>258</sup> [Spire response to the Remedies Notice](#).

Royal College of Surgeons, should be responsible for the oversight and enforcement of such a remedy.<sup>259</sup>

2.509 Ramsay expressed concern with the CC's proposal that the private hospital operators should publish consultants' fees on their websites, noting that around [✂] consultants had practising rights at Ramsay's private hospitals, with this remedy requiring the group to upload and update as appropriate fee information for each of these consultants. Ramsay argued that this represented a considerable administrative burden and raised concerns about publishing information on its website in circumstances where it was not necessarily possible for Ramsay to confirm and ensure that the information was up to date and generally accurate. As an alternative, Ramsay proposed that the information on consultant fee schedules be held on a central registry, operating in a similar manner to PHIN, where patients could compare fees across all consultants.<sup>260</sup>

- *Others*

2.510 The Independent Doctors' Federation (IDF) agreed that patients should be kept informed of fees in advance in an open and transparent manner. It believed that consultants should be free to set their own fees and to charge top-up fees if they so wished, but should not leave patients with unexpected shortfalls. However, it raised a number of concerns regarding publishing fees on websites, questioning whether all patients should be charged the same fee for consultations regardless of length, complexity or funder. The IDF also noted that publishing fees could have an inflationary effect, as most doctors would not wish to be seen as the 'cheapest'.<sup>261</sup>

---

<sup>259</sup> [Nuffield response to the Remedies Notice](#), paragraphs 7.1–7.3.

<sup>260</sup> [Ramsay response to the Remedies Notice](#), paragraphs 7.3–7.5.

<sup>261</sup> [IDF response to the Remedies Notice](#).

2.511 Finally, IDF argued that it was not always possible for consultants to estimate fees in advance, since which investigations would be required would not be known until after a provisional diagnosis had been made. Similarly, it might also not be possible to know what would be found during some procedures or predict which complications might occur.<sup>262</sup>

2.512 FIPO supported the idea that all consultants should provide information on their fees in advance, rather than this being limited to consultants with income over a given level. FIPO also argued that consultants should be allowed to set their fees at whichever level they saw fit, with patients able to ‘top up’ if their insurance policy would not cover the full cost.<sup>263</sup>

2.513 The AAGBI put it to the CC that in the majority of cases it was practicable for patients to be provided with a quote in advance of treatment but that it was not necessary to specify that this should be in writing, since the provision of this information over the telephone or verbally would achieve the same effect. The AAGBI suggested that patients should be encouraged to compare fee estimates with insurers’ benefit maxima and could confirm on admission to a hospital that they had been made aware of the fee in advance. In addition, the AAGBI proposed that a consultant be permitted to inform patients that all fees would be met by PMIs’ benefit maxima, in which case specific information on the exact fee would not be required. In the case of anaesthetists, the AAGBI proposed that hospital management and surgeons:

should be directed to have a duty to assist anaesthetists in providing estimates within an acceptable timescale. Consultant Anaesthetists should provide Consultant Surgeons with a list of their proposed fees, or a website link, or phone contact, so that all the professional fees and

---

<sup>262</sup> [IDF response to the Remedies Notice](#).

<sup>263</sup> [FIPO response to the Remedies Notice](#), paragraphs 4.3, 4.19 & 4.20.

hospital charges can be provided to the patient at the surgical consultation.<sup>264</sup>

2.514 The AAGBI highlighted that it would not be possible to provide advanced fee estimates to emergency patients and that any advanced estimates should contain caveats relating to changes to treatment, or the development of complications. In terms of the length of notice provided to patients, it suggested that five days should generally be sufficient, although flexibility should be provided for when patients wanted to be treated more quickly than that.<sup>265</sup>

2.515 Finally, the AAGBI suggested that the private hospital providers be required to collect data on the proportion of patients given fee estimates in advance within the agreed timescales, which would then be considered part of the accreditation process required by the CQC.<sup>266</sup>

2.516 The OFT noted that if fee information were provided to patients after they had already made an initial consultant choice, they might be reluctant to switch to another consultant and therefore patients should be made aware of fees as early as possible.<sup>267</sup>

### *Assessment*

2.517 The principal aim of the CC in requiring consultants to provide additional information on their fees is to stimulate competition on price between consultants by facilitating shopping around by patients. In addition, greater transparency on the full costs of consultant services should avoid patients facing unexpected expenses.<sup>268</sup> In this

---

<sup>264</sup> [AAGBI response to the Remedies Notice](#), Remedy 6.

<sup>265</sup> *ibid*, Remedy 6.

<sup>266</sup> *ibid*, Remedy 6.

<sup>267</sup> [OFT response to the Remedies Notice](#), paragraph 3.

<sup>268</sup> This occurs when a patient's medical insurance will only meet a part of the total cost of treatment and the patient was not aware of this in advance.

context, we have considered *what* information should be communicated to the customer, *when* this information would be most helpful, and in *which format* the information should be conveyed.

2.518 We agree with Bupa, AXA PPP and WPA that patients' ability to choose between consultants on price would be maximized by having information on the (consultant) costs of *all elements* of their treatment *in advance of the first outpatient visit*, including fees for outpatient and follow-up consultations, as well as medical or surgical treatments. We share the OFT's concern that once a patient has attended an outpatient consultation with one consultant, they are likely to face switching costs in moving to another consultant.<sup>269</sup> However, we recognize that, in many cases, this will not be feasible, since treatment pathways may vary significantly across patients and consultants will have limited information at the time of making an initial appointment on which to base an estimate of the fees the patient is likely to incur. Moreover, the provision of poorly-tailored information at this stage may mislead rather than inform patients as to the level of costs they are likely to face.

2.519 As regards the format of the fee information, given the range and potential complexity of the information provided<sup>270</sup> and the potentially vulnerable state of a patient, we consider that it should be provided to patients in writing (including email) to ensure clarity in terms of which services are covered in each element of the fee information and which are not. In the longer run we consider that it would be preferable for consultants' fees to be published on both their own websites<sup>271</sup> and a centralized website where fees could be compared rather than only provided in writing to patients once they have made an outpatient appointment. However, we recognize

---

<sup>269</sup> These switching costs are both financial—incurring a second initial outpatient consultation fee—and psychological, ie the feeling of being discourteous or disloyal by changing consultant after establishing a rapport with them.

<sup>270</sup> For example, a fee quote may include surgery, with the associated surgeon's and anaesthetist's fees, as well as follow-up consultations and outpatient treatments.

<sup>271</sup> In the case in which the consultant has their own website.

(and share) the concerns of the insurers that publication of fees, without accompanying information on quality, may result in upwards pressure on prices.

2.520 In terms of the level of fee information provided to patients, we consider that a consultant who has received a referral letter from a GP should be able to provide a complete fee quote for the initial outpatient consultation. This should take the form of either a fixed fee for the consultation or, where there can be significant variability, the basis on which the fee will be charged. For example, a consultant could quote a price per 30 minutes of consultation time. A similar quote should be provided to patients in advance of any and all subsequent consultations.

2.521 Following diagnosis, patients should be given a detailed and complete written quote for any surgical or medical treatment in advance of starting that treatment. This quote may be dependent on the treatment pathway provided that all the reasonable options are clearly set out. Where this quote does not cover unforeseen complications, this should be clearly stated.

### *Modified Remedy 6*

2.522 Our revised proposal for the provision of information on consultant fees would take the form of an order to private hospitals to require, as a condition of granting practising privileges, that (all) consultants provide fee information to patients using standard letter templates provided by the hospital. Hospital operators would be responsible for ensuring that consultants complied with this requirement.



2.523 At the time of confirming initial or subsequent outpatient consultation appointments, consultants should be required to provide patients with written confirmation of:<sup>272</sup>

- (a) the cost of the outpatient consultation, which may be a range<sup>273</sup> but, if so, should be accompanied by an explanation of the factors that will determine the actual fee level within the range;
- (b) details of any financial interests (shareholdings or otherwise) that the consultant holds in medical facilities or equipment;<sup>274</sup>
- (c) a list of all insurers which recognize the consultant;
- (d) a note encouraging insured patients to check the terms of their policy with their insurer, with particular reference to the level of outpatient cover they have; and
- (e) the address of the information organization<sup>275</sup> website, with a statement that this contains useful information on hospital and consultant quality information.

2.524 At the time of recommending or confirming further treatment, whether surgical, medical or other, the consultant should provide patients with written confirmation of:

- (a) their diagnoses;
- (b) a fee quote for the specific treatment (pathway) recommended for the patient. For insured patients, this should either include all consultant fees that will be charged separately from the hospital fee (surgeon, anaesthetist, radiologist etc.), or should include contact details for any specialists whose fees are not included in the quote provided. For self-pay patients, the letter should set out the package price of the treatment. These quotes should clearly state which services are included in the fee and which are excluded, such as unforeseeable complications. Where there are treatment options and the appropriate option can

---

<sup>272</sup> This could be delivered either by email or post.

<sup>273</sup> A range may be appropriate, for example, when the length of the outpatient consultation may vary significantly.

<sup>274</sup> See Remedy 4 on clinician incentives.

<sup>275</sup> In Remedies 5 and 7, the CC has proposed that hospital and consultant quality data be published by an information organization on its website.

only be selected during surgery, these should be set out clearly with the associated fees.<sup>276</sup>

2.525 The CC proposes that all private hospital operators in the UK be covered by this requirement. These operators would be required to provide consultants with appropriate template letters meeting the requirements set out above.

2.526 We envisage that the information required in each type of communication should be set out in either a letter or email to the patient in a clearly legible font.<sup>277</sup> The first letter should be sent at the same time as the outpatient consultation is confirmed with the patient. The second letter should be sent within 48 hours of the final outpatient consultation and prior to surgery (whichever is sooner).

2.527 The private hospital groups would be required to ask every patient undergoing treatment<sup>278</sup> at their facilities to confirm (by signing) that they received the above information in advance. Where consultants do not provide sufficient information to patients, it would be the hospitals' responsibility to enforce compliance.

2.528 It seems likely that private hospital operators would be able to introduce these requirements on consultants practising at their facilities within six months of the order being made.

2.529 Finally, we would require consultants practising privately to submit information on their outpatient consultation fees and standard procedure fees to the information organization by December 2016 for publication on its website alongside information

---

<sup>276</sup> For example, where an investigative procedure could be followed by surgery immediately if a problem were found but with no further action if there were no problem, the letter should set out these options and the associated fees for all treating medical specialists.

<sup>277</sup> For example, size 11 or larger, Arial or Times New Roman font.

<sup>278</sup> 'Treatment' comprises any inpatient, day-case or outpatient procedure, including diagnostic tests and scans.

on consultant performance. This fee information should cover all procedures undertaken by the consultant in his/her private practice.

### *Effectiveness*

2.530 The majority of respondents to the Remedies Notice did not question the effectiveness of providing additional information to patients on consultant fees in terms of helping patients to 'shop around' or in preventing the occurrence of unexpected shortfalls. The OFT raised concerns that once a patient had made an initial choice of consultant they may be reluctant to switch providers. We recognize that the remedy set out above does not allow patients to compare consultation fees prior to making an initial outpatient appointment or procedure fees prior to receiving a diagnosis. However, a large number of parties suggested to us that the publication of consultant fees prior to the release of substantive information on consultant quality may have an inflationary effect, defeating one of the aims of the remedy. We share this concern and have taken it into account by modifying our proposed remedy, as set out above. However, in the next three years the CC's proposed Remedy 5 (consultant performance information) should increase the availability of consultant performance information. We consider that once this information is available to patients, the publication of consultant fees information should stimulate competition on value, rather than serve to push up consultant fees. Therefore, we have only specified that information on consultant fees should be published once information on consultant quality is also available to patients.

2.531 We recognize that many patients, particularly those with medical insurance, may not choose to 'shop around' even if given the information with which to do so. However, we consider that for this remedy to be effective, it is only necessary for a relatively small but significant proportion of private patients to do so. The survey undertaken by GfK for the CC indicated that 29 per cent of patients cited whether or not their PMI

would cover a consultant's fees to be an important reason for choosing a particular consultant. In addition, 10 per cent of patients surveyed indicated that they would be prepared to travel further for a lower-cost consultant or a lower-cost hospital. This suggests that a reasonable proportion of patients are price-sensitive, at least to the extent that they may be required to make co-payments and hence are likely to use this information to shop around. Furthermore, insured patients, if provided with consultant fee information suggested, would be better placed to determine the extent of their policy coverage as early as possible in the process and make choices in terms whether to claim on their policy and/or pay any additional fees not reimbursed by their insurer.

### *Proportionality*

2.532 The two principal benefits that we foresee resulting from this remedy are competition among consultants on the basis of price and the avoidance of unexpected costs for patients. In the case of the former, we note that total specialist fees charged for treating private patients in the UK were £1,585 million in 2011.<sup>279</sup> Although it is not possible to quantify what proportion of this cost may be saved by patients as a result of increased competition between consultants, even a 2 per cent average decline in prices is equivalent to a £31.7 million decline in costs annually, some of which will be saved directly by patients, via lower shortfalls, top-ups and/or co-payments, and some by the PMIs, which we would expect to be passed through to patients in lower insurance premiums. While the extent to which PMIs would pass through lower costs will depend on the level of competition in the insurance market, economic theory suggests that this will range from full to partial depending on the nature of competition in providing private medical insurance.

---

<sup>279</sup> Laing & Buisson, 2012/13.

2.533 We considered that the following costs would be associated with implementing this information remedy:

- (a) Staff time at the hospitals adjusting the terms of practising privileges agreements, producing template letters for consultants and checking with patients that they had received them.
- (b) Consultant time in collating information on the fees and contact details of the other specialists with whom they work.

2.534 We expect that the majority of these costs would be associated with setting up the letter templates and collating information on specialists' fees initially, with relatively minor ongoing costs of maintaining up-to-date lists. We understand that, in accordance with guidance from the relevant professional bodies as well as a previous Monopolies and Mergers Commission recommendation,<sup>280</sup> many consultants already provide some fee information to patients. For these consultants, we believe that this remedy would represent minimal additional time, with the introduction of template letters potentially representing a time saving. For consultants who are not currently providing written fee information, this remedy will represent an additional administrative task, although we would not expect the time involved to exceed 5 minutes of consultant time per patient, assuming secretarial support.

2.535 Therefore, we conclude that the costs associated with this remedy are immaterial and likely to be outweighed by the benefits to patients in enabling them to make more effective choices especially in the longer term when both consultant performance and fee information is made available. As a result, we consider that this remedy is proportionate in addressing the AEC that we have identified arising as a result of the lack of information available to patients on consultant fees.

---

<sup>280</sup> MMC Inquiry into the supply of Private Medical Services, 1994, paragraph 11.164.  
[http://webarchive.nationalarchives.gov.uk/20111202195250/http://competition-commission.org.uk/rep\\_pub/reports/1994/348privmedical.htm#full](http://webarchive.nationalarchives.gov.uk/20111202195250/http://competition-commission.org.uk/rep_pub/reports/1994/348privmedical.htm#full)

### **3. Remedies we do not intend to pursue**

#### ***Introduction***

- 3.1 In this section we describe remedies that we have considered but do not intend to pursue, setting out our reasons. We first set out our reasoning as regards remedy options that we included in our Remedies Notice. We then describe remedies proposed to us by parties which we do not intend to pursue, setting out our reasons.

#### ***Remedies contained in our Remedies Notice***

##### ***Remedy 2 (constraints on private medical insurer/private healthcare provider contract terms ('tying and bundling'))***

- 3.2 We identified two structural features in the provision of privately-funded healthcare by hospitals:
- (a) high barriers to entry for full-service hospitals; and
  - (b) weak competitive constraints in many local markets, including central London.
- 3.3 Together these features give rise to AECs in the markets for hospital services that are likely to lead to higher prices for self-pay patients in certain local markets and to higher prices for insured patients for treatment by those hospital operators (HCA, BMI and Spire) that have market power in negotiations with PMIs.<sup>281</sup>

##### ***The proposed remedy and how it seeks to address the AEC***

- 3.4 Our Remedies Notice included divestitures which would address the market power of these groups but noted that, outside of central London, there were areas which we characterized as Single and Duopoly areas where divestiture remedies would be ineffective.

---

<sup>281</sup> Provisional findings, paragraphs [6.248\(a\)](#) & [10.3](#).

- 3.5 We therefore set out in our Remedies Notice a behavioural remedy (Remedy 2), the aim of which was to place limits on the extent to which BMI, HCA and Spire could exploit their local market power when negotiating terms with PMIs nationally. For convenience, we referred to these practices collectively as ‘tying and bundling.’
- 3.6 The proposed remedy addressed two specific types of conduct that PMIs had said that hospital operators engaged in:
- (a) raising, or threatening to raise, prices across all their hospitals in the event that a PMI recognized a rival on its network; and
  - (b) raising, or threatening to raise, prices across all their hospitals if a PMI proposed reducing the number of hospitals it recognized in a group.<sup>282</sup>
- 3.7 The first, Remedy 2(a), would prevent contractual terms between BMI, HCA or Spire with the PMIs from triggering price increases across their hospital estate if a PMI changed its network policy such that patient volumes to the hospital operator concerned might fall at one or more of its hospitals. This could occur if, for example, the PMI chose to remove one of the operator’s hospitals from its network or if it added a rival hospital to its network.
- 3.8 The second, Remedy 2(b), would require BMI, Spire and HCA to offer and price their hospitals separately and individually to PMIs. It rested on the assumption that in these circumstances the hospital operator would charge lower prices in competitive areas than when previously offering a ‘blended’ national price, but would be deterred from raising prices in areas where it faced little or no competition by the threat of new entry or by reputational risk.

---

<sup>282</sup> In circumstances where the hospital operator was said to have required significantly higher prices at its hospitals unless the PMI recognized all of them this tactic was described as ‘one-in, all-in.’

3.9 We invited views on:

- (a) the likely effectiveness of this remedy, including how quickly it would come into effect and whether it was likely to be practicable and not prone to circumvention risks;
- (b) whether the remedy would be reasonable, including whether a hospital operator might have appropriate grounds for seeking a price increase in response to a diminution of business; and
- (c) what monitoring and enforcement mechanisms it would require in order to be effective.

*What parties told us*

- *PMIs*

3.10 Bupa told us that it did not think that, on its own, either remedy would be effective since neither addressed the source of the hospital groups' market power: their 'must have' hospitals.<sup>283</sup> It said also that both remedies were liable to be circumvented and could give rise to unintended consequences. It said that if the CC decided to adopt these remedies then they should apply also to Ramsay and Nuffield.

3.11 Regarding Remedy 2(a), Bupa said that hospital groups could adopt a variety of tactics other than across-the-board price increases to punish PMIs and it gave us some examples of these.

3.12 In addition, Bupa said that this remedy risked giving rise to unintended consequences. It said that hospitals might be deterred from offering price/volume discounts at all if they were locked into a price no matter what changes in volume took place. In addition, hospital operators might decline to participate in new, for instance, low-cost networks in response to PMIs using the rights that this remedy would confer on them.

---

<sup>283</sup> [Bupa response to the Remedies Notice](#), paragraphs 4.128–4.165.



- 3.13 It said that were price increases to be reviewed by, for example, the CMA to establish whether they were punitive, this would take time and create uncertainty. It therefore believed that, should this remedy be introduced, then a dedicated, standing private healthcare adjudicator should be put in place, whose general overheads should be funded by the main hospital groups but that the costs of specific disputes should be borne by the parties concerned.
- 3.14 Bupa said that Remedy 2(b) would not be effective, as hospitals would raise prices above their previous levels in areas where they faced little or no competition since the high barriers to entry that the CC had found would make it unlikely that a new rival would enter the local market. Bupa said that hospital groups could also circumvent the remedy by delaying agreement for terms on 'must-have' hospitals until they had been agreed for hospitals facing competition.
- 3.15 AXA PPP said that it did not consider the competition issues that it faced outside of central London were of the same magnitude as those in central London and that Remedy 2 might give rise to unintended consequences.<sup>284</sup> These included that it could blunt a PMI's bargaining strategies by preventing it from using its bargaining power in competitive areas to achieve better terms in Single areas. However, in order to make entry easier it proposed a carve-out whereby an incumbent which lost its exclusive or privileged status with a PMI following a local re-tendering exercise would be prevented from raising prices nationally.
- 3.16 AXA PPP said that Remedy 2(a) would prevent automatic, contractual and immediate price increases but would not prevent higher prices in the next contract round. It did not consider Remedy 2(b) to be either necessary or practicable.

---

<sup>284</sup> [AXA PPP response to the Remedies Notice](#), paragraphs 2.67–2.103.

- 3.17 PruHealth said the intentions of the remedy were welcome but thought that the requirement of Remedy 2(b) to negotiate prices for each hospital separately and independently would be onerous in resource terms.<sup>285</sup>
- 3.18 In its written submission Aviva said, in general terms, that since the CC's structural remedies would not affect the large numbers of areas where there were single or duopoly hospitals, a remedy which addressed the market power of hospitals in these areas was very important. It said that it preferred Remedy 2(a) to 2(b) as it was less onerous in resource terms but that the remedy should be applied to all the main hospital groups, ie Ramsay and Nuffield in addition to BMI, HCA and Spire.<sup>286</sup> Nonetheless, Aviva also said that Remedy 2(a) was liable to circumvention as hospitals could negotiate volume discount terms which incentivized recognition of all their hospitals. It also said that the remedy would require significant levels of monitoring and enforcement.
- 3.19 At our hearing, Aviva said that its thinking on this remedy had developed and that a more local, geographic focus to negotiation had advantages for Aviva, for the market and for customers. It reiterated, however, that the remedy should apply to all hospital groups in order to 'future-proof' it.
- 3.20 WPA said that Remedy 2(a) would only be relevant to a PMI that offered a restricted network of hospitals, which it did not. It said that it would be unlikely that many insurers would wish to take on the administrative burden of negotiating all prices separately and that no-one would wish to have 30+ sets of individual prices and charge masters each running to several thousand items.

---

<sup>285</sup> PruHealth response to the Remedies Notice.

<sup>286</sup> Aviva response to the Remedies Notice, pp5–7.

3.21 Simplyhealth said that tariffs were likely to be related to volumes in the longer term and, as a result, the effect of Remedy 2(a) was likely to be limited. It said that Remedy 2(b) would not be practical other than for the two largest PMIs and might therefore make them even more powerful.<sup>287</sup>

- *Hospital groups*

3.22 BMI, in relation to Remedy 2(a), said that it had considered what the CC's proposal might mean and what it was trying to achieve. It first considered whether the CC intended to prohibit contractual provisions that prevented BMI from altering national prices as a result of changes in local network policy. It said that if this were the case then the remedy would be ineffective, unnecessary and disproportionate [§].

3.23 It next considered whether the CC intended to prohibit contractual provisions that prevented BMI from altering local prices as a result of changes in local network policy. It said that some insurers opted to procure private healthcare services on the basis of exclusive or tight networks with a limited choice of hospitals. The insurer would then ask the hospital operator for lower prices on the basis that a limited number of competing hospitals would be included in the network, as a result of which the hospital operator could expect more of the volume generated by the network policy. BMI said that any procurement conducted on this basis was likely to have a restriction on being able to add other hospitals to the network. [§], citing the entry of Circle to the Bath market and its and AXA PPP's evidence that it had not raised prices in Bath nor threatened to do so when Circle sought to enter that market. BMI said that [§] demonstrated that a prohibition of this provision would be highly likely to be ineffective.

---

<sup>287</sup> [Simplyhealth response to the Remedies Notice](#), pp5–8.

3.24 BMI then considered whether the CC intended to prohibit tight/restricted or exclusive PMI networks. It said that the main restrictive networks were with AXA PPP, which operated a regional pricing structure. It said that AXA PPP had recognized the risk that tight or restricted networks ‘may be materially or even fatally undermined by the imposition of a ban on tying/bundling’. It said that the proposed remedy would remove any incentive for BMI to operate such arrangements and remove from PMIs a commercial choice that some of them had legitimately chosen. BMI said that the CC had conducted no analysis of the competitive effect of exclusive or tight networks and had offered no evidence of any foreclosure effects or that such foreclosure effects were of sufficient importance to make intervention against them either effective or proportionate. It said that, without such analysis, the CC had no rational basis to consider whether the adverse effect of the remedy was disproportionate to its aim. It said that, as the CC had no evidence and had not conducted such analysis, it could not be the intention or effect of Remedy 2(a) to ban or restrict exclusive or tight networks.

3.25 It next considered whether the CC intended to prohibit contractual provisions that prevented BMI from altering national price as a result of a change in local network policy, where that change had an effect on volumes treated by BMI. It noted that [REDACTED], although changes in network policy could alter national price indirectly if delisting resulted in reduced volume. [REDACTED]; network definition was a matter for the insurer. It said that banning hospital operators from adjusting price to reflect reductions in volume (including those that resulted from changes in network policy) would incentivize PMIs to over-promise volume, in the knowledge that under-delivering via network alteration would attract no consequences. It would also mean that hospital operators would no longer have any rational basis to offer volume discounts at all. It said that the CC could not seek to allow PMIs to renege on volume promises that justified a given price; the remedy would amount to unlawful confiscation and was

disproportionate to the aim pursued. According to BMI, the CC was wrong to assume that a delisting in, say, Guildford should not affect the price in, say, Glasgow, as costs were not predominantly local. BMI had a large amount of cost that was incurred centrally<sup>288</sup> and these costs would not reduce in proportion to the loss of volume if a hospital was delisted by an insurer. It said that Bupa was wrong to imply to the CC that BMI's central costs either were low, or should be low. Centralizing a number of functions led to greater efficiency and improved customer benefits.

- 3.26 BMI then asked what the CC expected would happen to the national price/volume relationship as a result of delisting at a local level, and whose national price/volume relationship the CC anticipated would change as a result of a delisting by a given PMI. It provided charts showing the impact on volumes at Lancaster following its delisting by Bupa for a period during 2011/12. It said that Bupa's year-on-year volumes had [X] between January and July 2012, and other insured work had [X] (partly as a result of 'consultant drag effect' as consultants shifted to other hospitals where they could treat all their insured patients). It said that delisting a local hospital meant that average costs at that hospital would rise, potentially very significantly. The PMI delisting the hospital would not bear these costs as it no longer used it; instead, these costs would be borne by a combination of BMI and the other remaining private customers of the hospital. As a delisting also removed volume assumptions underpinning investment in the hospital, BMI said that the consequence was likely to be adverse changes to the hospital offering. The CC should therefore expect a remedy that facilitated delisting rapidly to undermine the viability of the delisted hospital, or to force it to raise its prices to recover costs over a smaller volume. It should also expect investment incentives to be harmed and the cost of capital for hospitals to be raised.

---

<sup>288</sup> Examples cited were: [X].

- 3.27 It said there appeared to be three theoretical options following a delisting:
- (a) the delisted hospital lowered prices (or increased investment) to retain such volume as it could and tempted back the delisting PMI;
  - (b) the delisted hospital imposed steep price rises for remaining users of the facility to recover its costs; or
  - (c) BMI closed the hospital as it could not recover its fixed costs or, alternatively, reduced the capital invested by decommissioning high-cost services such as ICU, moving equipment and cancelling earmarked investment.
- 3.28 For the remedy to be effective and proportionate, it said the CC would have to have a reasonable, evidence-led expectation that the outcome in paragraph 2.27(a) was the most likely. However, it was doubtful whether this would be the outcome. BMI said that, [REDACTED].<sup>289</sup> Further, as no PMI offered local pricing, a discount strategy by BMI at a local hospital would not be passed through to the PMI's customers so as to result, over time, in potentially increased patient demand. It said that it was more likely that a sharp decrease in fixed-cost coverage in a local hospital would result in either sharp price rises for private patients who used the facility, or closure. Raising prices would mean that competing PMIs would face sharply higher costs in a given local area as a result of the actions of a delisting competitor (and they might be expected to resist such price increases). It said that, if the CC prevented a national price/volume curve operating in the event of a local delisting, [REDACTED]. If the hospital could not be closed (eg [REDACTED]), local prices would rise sharply. If the hospital still lost money, BMI would be forced to carry the cost, [REDACTED].
- 3.29 More widely, BMI said that the implications of Remedy 2(a) increasing delisting events and hospital closures could be expected to be substantially raised barriers to entry and reduced pricing certainty for PMIs (as BMI's ability to offer forward prices

---

<sup>289</sup> [REDACTED]

declined with insurers' greater incentive to delist hospitals). Greater uncertainty for hospital operators and increased investment risk would increase private healthcare providers' cost of capital. BMI said that the CC had not properly specified Remedy 2(a), and it was likely to be unworkable, ineffective and disproportionate.

- 3.30 In respect of Remedy 2(b), BMI said that it was content to offer (and had in the past offered) pricing that varied by hospital or by local area (although Bupa had refused such an offer in respect of the low-cost network). It said that AXA PPP and the NHS both had differential pricing by geography. While BMI had no objection in principle to hospital-by-hospital pricing, it was uncommon as it increased transaction costs. It said that the only market participant which would benefit from individual pricing of hospitals was Bupa, as its volumes in each hospital meant that it would be able to negotiate from a position of strength. Bupa already had a large team of analysts and negotiators in situ, and therefore would probably not incur significant additional costs, as would be the case with other PMIs. As for the hospital operators, the costs of this remedy would fall disproportionately on BMI, as it had the largest portfolio.
- 3.31 It said that package prices would be extremely difficult to calculate on a purely local basis as there were insufficient episodes over which cost could be observed. Likewise, Remedy 2(b) would have the unintended consequence of rendering localized hospital volume discounts highly volatile, as volumes by insurer were highly volatile on a hospital-by-hospital basis. This would reduce pricing certainty and increase underwriting risk for PMIs, leading to higher PMI premiums.
- 3.32 BMI said that its ability to raise prices in a given local area, even where it had high market share, was significantly constrained by the severe public backlash that it would suffer from the PMIs, especially Bupa. The ensuing damage to its reputation would make BMI reluctant to engage in such pricing. High local prices would also

foster new entry into that market. In BMI's view, Remedy 2(b), as stated, would add significant complexity to negotiations and costs both to BMI and PMIs. It said there was no demand for it from PMIs (except Bupa) and the CC should be careful to avoid conferring yet further advantage on Bupa, which had most to gain from its implementation.

3.33 Finally, BMI proposed an alteration to the CC's tying and bundling proposal. [✂]

3.34 HCA said that if Remedy 2(a) had the effect of preventing a hospital from varying its prices on the basis of patient volume changes, this was the equivalent to a price control.<sup>290</sup> HCA noted that, given the cost structure of hospitals, changes in patient volumes affected costs across its hospitals. It said that a remedy which prevented the parties from reviewing or renegotiating contract prices in response to changes in volume would not be reasonable or proportionate and would incentivize the parties to enter into shorter-term contracts to guard against mid-contract changes in network composition. Further, HCA said that as it operated its hospitals within the same geographical area, London, and on a network basis, whereby the patient journey might encompass several hospital facilities, a fall in volume at one of its hospitals would affect take-up in another. It would therefore be legitimate for HCA to reflect this in its pricing.

3.35 HCA said that the CC's aims were more likely to be achieved by tackling contractual restrictions which directly related to and restricted a PMI's power to change its network. These included:

(a) exclusivity provisions: exclusivity clauses specifically restricting a PMI from changing its network policy for the duration of the contract;

---

<sup>290</sup> [HCA response to the Remedies Notice](#), Section 7.



(b) non-recognition clauses: any clauses which required a PMI not to recognize designated competitors; and

(c) targeted price clauses: clauses which triggered a price review expressly because of a PMI's recognition of a designated competitor.

3.36 HCA said that the remedy as set out by the CC would prohibit particular types of contract provision and parties must therefore be given a full and fair opportunity to, where appropriate, terminate any existing arrangements or to allow current fixed contracts to expire and renegotiate new contracts.

3.37 On Remedy 2(b) HCA said that it was able to price its hospitals individually, but that PMIs had not previously sought to negotiate terms of access to HCA's hospitals on an individual basis. HCA told us that it operated a network of facilities in London and that there were cost and other benefits in PMIs accessing the whole network of hospitals for their subscribers. HCA said that there would be serious implications for its network and the financial viability of its hospitals if either Bupa or AXA PPP delisted individual HCA hospitals.

3.38 Spire said that Remedy 2(a) was not justified since the CC's provisional findings did not identify any AEC resulting from tying, bundling or national discount schemes.<sup>291</sup> It said that the application of the remedy remained unclear and it was therefore difficult for Spire to comment meaningfully on it. It said that the remedy, if applied to agreements already concluded between Spire and insurers, would not [X]. However, it said that it had concerns that the remedy could be interpreted more widely: (a) as preventing hospital operators from enforcing their mutually-agreed contractual rights if a PMI were to delist a hospital during the course of a contract; or (b) as applying to successive rounds of contracts between hospital operators and PMIs.

---

<sup>291</sup> [Spire response to the Remedies Notice](#), pp18–37.

- 3.39 Spire said that the CC appeared to suggest that that it would always be economically viable for a hospital provider to retain discounts at its remaining hospitals were a PMI to delist one or more of its other facilities and services. Spire said this was incorrect and that its pricing reflected the inclusion of a broad basket of services with costs varying between facilities and specialities. It said that national pricing also reflected the fact that many of the costs in Spire's hospitals were shared across specialities. It said that if one of the specialities that made use of a shared service was removed, it might not be economically viable to operate that shared service at that facility. As an example of this it said that the imaging and surgical services associated with cancer services relied on other, non-cancer, work to achieve the volumes required for a minimum efficient scale. More generally, Spire said that the proposed remedy ignored the fact that there were several reasonable grounds to support price increases where a PMI reduced its volume of business.
- 3.40 Spire said that the remedy would be complex to implement and monitor, would give rise to unintended consequences and was disproportionate. Spire considered the remedy disproportionate because it would apply to all pricing changes, even if not connected to network policy; that it would apply to all forms of treatment even though the CC's analysis was limited to inpatient treatment; and that it was disproportionate to the concerns identified by the PMIs. Spire suggested that the remedy would likely result in private healthcare providers and PMIs moving to shorter-term local pricing and that, as a result, Remedy 2(b), which would directly lead to local pricing, would be a more reasonable and effective alternative.
- 3.41 Spire said of Remedy 2(b) that the remedy was not justified since the CC's provisional findings did not identify any AEC resulting from tying and bundling but that, despite this, the remedy could be implemented without material practical difficulty. It said that one practical solution to implementing the remedy would be for a PMI and a

hospital operator to negotiate a national 'standard rate' for all procedures and codes and then to negotiate discounts from and premiums to that rate for hospitals as was deemed appropriate by the parties to the negotiation. It said that material changes to its existing arrangements with PMIs would be required and, to avoid unnecessary disruption, these might be introduced as existing contracts expired. In the case of contracts with no fixed expiry dates, 12 months should be allowed for existing terms to be renegotiated.

3.42 Spire thought that if prices were negotiated on this basis it would not necessarily mean that they would rise in single hospital areas. Spire noted, as a starting point, that it disagreed with the CC's suggestion that any of its facilities operated in single hospital areas. It said that, first, single hospital areas were often characterized by low PMI penetration and, consequently, were of lesser importance to PMIs. It said that such hospitals faced a greater risk of delisting because a PMI would require only a small number of patients to travel further to receive treatment. Second, it said that increased prices in single hospital areas would be likely to elicit new entry, assuming sufficient PMI penetration. It said that new entry might not need to be in the form of a full-service hospital but could be a day-case and outpatient centre or a satellite facility of an operator in an adjacent area. Third, it said that few PMIs currently differentiated their prices by location. Accordingly, if prices were to rise in Single areas, it could not simply be assumed that PMIs would raise consumer prices locally. If PMIs did pass on local price increases directly to customers in the area, a single hospital which raised its prices would face the loss of insured customers, which would limit a hospital operator's incentive to raise prices.

3.43 Finally, Spire said that consumer detriment would arise if the proposed remedy were to lead Spire to close one or more of its hospitals. It said that, broadly speaking, any remedy that could increase the likelihood of a major PMI delisting one of Spire's

hospitals would increase the likelihood that Spire would close that hospital. It said that consumer detriment could also arise if the remedy were to lead to a 'race to the bottom' whereby hospitals focused on competing solely on price, though it said that this risk could be offset by allowing higher-quality hospitals to charge top-up fees.

- 3.44 Nuffield said that the remedy would not prevent hospital operators tying group hospitals together and leveraging their must-have hospitals.<sup>292</sup> Regarding Remedy 2(a), it said that hospital operators could make selective recognition of their hospitals uneconomic through 'price tiering' and it would be difficult to distinguish between genuine volume discounts and rates designed to penalize a PMI. Nuffield said that such a scheme would be difficult, complex and expensive to monitor. It said that Remedy 2(b) would be onerous because of the higher costs entailed in negotiating hospital contracts separately.
- 3.45 Ramsay said that although it would not be subject to Remedy 2(a) it believed that, [REDACTED].<sup>293</sup> Ramsay told us that prices were negotiated on the basis of expected volumes. If a PMI removed a hospital from its network during a contract, Ramsay would expect that prices would be opened for renegotiation. It said that to insist that a hospital group's prices remained unchanged in these circumstances was unfair and unreasonable.
- 3.46 Ramsay said that Remedy 2(b) would give rise to a number of unintended consequences. It would raise costs because the cost of negotiating individual contracts would be higher than negotiating a single, national contract and higher administrative and transaction costs would give rise to higher prices for hospital services. It said that if terms were negotiated separately then [REDACTED]. It said that in these circumstances PMIs might divert patients to hospitals with lower charges rather than for purely

---

<sup>292</sup> Nuffield response to the Remedies Notice, Section 3.

<sup>293</sup> Ramsay response to the Remedies Notice, Section 3.

medical reasons. Finally it said that the smaller PMIs might be disadvantaged as they had fewer resources to cope with the additional burden of separate negotiations.

3.47 Circle told us that Remedy 2(a) was not complete in that it would only address one aspect of pricing negotiations between incumbent hospital operators and PMIs.<sup>294</sup> Whilst important, volume was not the only factor that was considered. For this reason Circle preferred Remedy 2(b). It said that the adoption of Remedy 2(b) was the only practical way to ensure that national market power did not factor in local negotiations and that its scope should extend to all multi-site hospital owners including Circle, Ramsay and Nuffield.

3.48 Circle argued, however, that in single hospital areas which were key to a PMI's network, the operator might charge two or three times prices prevailing in competitive areas or might use this power to deter a PMI from recognizing an entrant. As a consequence, Circle said that the CC should consider a price control remedy, as well as mandatory universal PMI recognition.

- *The Office of Fair Trading*

3.49 The OFT expressed concerns that Remedy 2(a) would require a high degree of monitoring, especially given the difficulty or impossibility of devising some bright-line definitions, such as when a hospital's price rise might be attributed to a change in a PMI's network arrangements. It suggested that an adjudication mechanism be created on the lines of those created in the local bus services market and in groceries for Groceries Supply Code of Practice (GSCOP). The OFT also suggested that, in the case of Remedy 2(b), compliance monitoring might be made easier if PMI and hospital agreements co-terminated.

---

<sup>294</sup> [Circle response to provisional findings and Remedies Notice](#), pp6&7.

*Our assessment*

3.50 We now consider aspects of the design of this remedy before concluding on its effectiveness and proportionality.

- *Design considerations*

3.51 We considered whether the two variants of the remedy that we set out in the Remedies Notice:

- (a) did not comprehensively address the forms of conduct that a hospital operator could potentially adopt to exploit its local market power in negotiations with PMIs;
- (b) were subject to circumvention risks; and
- (c) would not be effective unless accompanied by other measures.

3.52 We consider these arguments for each variant in turn.

- *Remedy 2(a)*

3.53 We considered whether Remedy 2(a) could be circumvented through the adoption by hospital operators of conduct other than that covered by this remedy. For example, a hospital operator could adopt volume discounts which would impose significantly higher costs on a PMI in the event that it either recognized a competitor or delisted a particular hospital. In these circumstances the hospital operator could claim that any price increases proposed were either unconnected to the PMI's change of network policy or cost reflective, rather than punitive.

3.54 Although we agreed with the OFT that certain bright-line definitions might be difficult to devise we thought that it might, in these particular circumstances, be possible to distinguish between volume discounts that were cost related and those which were intended to penalize a PMI. We thought, for example, that if a hospital group:

- (a) applied a price increase across all of its hospitals; or

(b) did so immediately (ie anticipating a fall in volume before it was evident), in circumstances where a PMI either recognized a rival or delisted one of its hospitals, this would be hard to justify on the basis that the price increases were cost reflective.

3.55 Our reasoning here was that, because of the high fixed costs of hospitals, changes in patient volumes would be likely to affect margins at the hospital affected by delisting or the recognition of a rival, but we could see little or no justification, on margin grounds, for an increase in prices across the rest of hospital owner's estate. Further we thought that to do so automatically, before any effect on patient volumes could be observed, could not be justified on the basis of costs. Consequently we thought that contract terms which gave effect to such arrangements should be prohibited.

3.56 HCA told us that its hospitals were substantially dependent on PMI revenues and that PMI recognition could make or break any hospital.<sup>295</sup> HCA argued that fluctuations in patient volumes affected costs across all of its hospitals as it ran them as a single, integrated network.<sup>296</sup> It said that it would be reasonable to raise prices across its network in the circumstances described above because of the economic and synergy benefits that its hospitals derived from being part of its network. It cited, as examples of these, its centralized IT team and access to common services.<sup>297</sup>

3.57 Our analysis of insured pricing in London cast some doubt on these arguments. This indicated that, despite offering similar services, HCA's prices to the major insurers are consistently above those of TLC which operates from one site and is not part of a group.<sup>298</sup> As HCA's prices are higher than those of its close competitors and its

---

<sup>295</sup> [HCA response to the Remedies Notice](#), paragraph 7.26.

<sup>296</sup> *ibid*, paragraph 7.7.

<sup>297</sup> *ibid*, paragraph 6.36.

<sup>298</sup> [Provisional findings](#), Appendix 6.12, Table 8.

quality is not discernibly better, then any cost benefits gained from its network structure do not manifest themselves in the form of relevant customer benefits.

3.58 HCA also argued that since it operated its hospitals in London as a single, integrated network, changes in volumes of patients attending one hospital in its group in London could affect the take-up of services at another.<sup>299</sup> While we accept that some patients, particularly those receiving treatment for cancer, may be referred from one HCA hospital to another depending on the nature or phase of their treatment, for example for radiotherapy or chemotherapy following surgery, we do not believe this pathway exists to the same extent within other specialisms. The evidence that HCA submitted mainly referred to patients receiving treatment for cancer and we have seen no other evidence to suggest that inter-hospital patient pathways exist to the same extent within other specialities.

3.59 We therefore provisionally concluded that Remedy 2(a) could be effective in addressing one particular form of hospital conduct: seeking to maintain its share of a PMI's patients/revenue by either automatically raising prices or by threatening to raise them across its entire estate. However, we accepted that there may be other, and perhaps many other forms of conduct designed to achieve the same end which may be less straightforward to identify. For example, it would be very difficult to demonstrate that a hospital operator had threatened not to participate in a new PMI network in order to deter the PMI from recognizing a rival or de-recognizing one of its hospitals rather than that it had declined to participate simply because the parties had failed to agree mutually satisfactory commercial terms.

3.60 We discuss these issues further below (paragraph 3.70 et seq).

---

<sup>299</sup> [HCA response to the Remedies Notice](#), paragraph 7.7.



- *Remedy 2(b)*

- 3.61 We considered whether the costs of negotiating hospital contracts separately and individually would be onerous. Some of the smaller PMIs said that this remedy would, accordingly, favour the larger PMIs.
- 3.62 We did not consider that this would necessarily be the case because we did not think that every price heading would need to be separately negotiated for each hospital. We thought it more likely that PMIs would negotiate a framework agreement with a hospital operator containing a 'rate card' of prices and that individual hospitals, or more likely groups of hospitals, would attract various levels of discount from the rate card.
- 3.63 Irrespective of how prices were negotiated, it was put to us that Remedy 2(b) would permit, and be likely to result in, hospital operators raising prices substantially above current levels at hospitals where:
- (a) there was little or no local competition; and
  - (b) it was important for a PMI to include that hospital in its network. This might, for example, be because the hospital was important to a corporate client with a concentration of employees in the hospital's catchment area.
- 3.64 Parties submitted that, as we had provisionally concluded that high barriers to entry existed in the private healthcare market, it would be unsafe to rely on the threat of entry to deter price increases. Consequently, it was put to us that this remedy was unlikely to be effective unless accompanied by additional measures.
- 3.65 We next considered whether there were other factors which would deter a hospital group from setting prices higher in areas where competitive constraints were weak than in areas where they were strong. We considered whether the risk of reputational

damage or of regulatory intervention under the Competition Act 1998, for example, would be an effective deterrent.

- 3.66 We did not think that we could rely on either of these risks to deter hospital operators from setting higher prices in areas where competitive constraints were weak though, on the basis of the reasoning that underlay our insured price analysis and AEC finding for HCA, BMI and Spire in relation to negotiations with PMIs, we thought that the average level of prices charged by a hospital group, in the event that it did price its hospitals differently, would probably be equivalent to the current 'blended' price.
- 3.67 We concluded that hospital operators would be likely to set prices in competitive areas lower than the current 'blended' price but would not be deterred from setting prices above the current level elsewhere by the threat of entry or other factors.
- 3.68 We next considered whether, if a hospital operator did charge higher prices for hospitals in areas where competitive constraints were weak, this would result in higher health insurance prices in that area which might in turn reduce the volume of insured patients it attracted. We thought that, in principle, if higher hospital charges were reflected in higher local health insurance premiums and this led to reduced PMI penetration then a hospital might be deterred from raising its prices. However, we noted that the 'post code pricing' for health insurance premiums was not universal or even common and that, as a consequence, customers would not be likely to receive the price signals that could otherwise arise.
- 3.69 We therefore concluded that Remedy 2(b) would not be effective in addressing the AEC that we had provisionally identified.

- *Additional measures*

3.70 We provisionally concluded that Remedy 2(a) could be effective but we accepted that there may be other, and perhaps many other, forms of conduct by hospital operators designed to achieve the same end which may be less straightforward to identify. We therefore considered whether the remedy design could incorporate additional measures to address these other forms of conduct.

3.71 One feature of behavioural remedies, as compared with structural measures, is that they do not address the underlying causes of a lack of rivalry as certainly. Consequently, while behavioural measures may address particular forms of conduct which have been identified during an investigation and through which market power is manifested, they may fail to address other, including new, forms of conduct through which a firm may exercise its market power. As noted in our Guidelines for Market Investigations:

Circumvention risks—It is possible that other adverse forms of behaviour may arise if particular forms of behaviour are restricted. For example, if prices are controlled a firm may reduce product quality. To avoid or reduce these risks, behavioural measures will generally need to deal with all the likely substantial forms in which enhanced market power may be applied.<sup>300</sup>

3.72 We considered first whether the number or type of forms of conduct specified by our remedy was comprehensive or should be extended. Remedy 2 as described in the Remedies Notice would address two specific forms of conduct: pricing tactics which give rise to barriers to entry, and the leveraging of local market power in national price negotiations. Other forms of conduct of which we were aware, some of which were specifically cited by parties as illustrating market power, included:

---

<sup>300</sup> CC3, [Annex B](#), paragraph 40(b).

- (a) non-recognition clauses: any clauses which require the PMI not to recognize designated competitors;
- (b) targeted price clauses: clauses which trigger a price review expressly because of a PMI's recognition of a hospital's competitor; and
- (c) 'most-favoured nation' type contract terms: preventing a PMI from favouring a competitor through its patient 'guidance' processes or excluding it from a network.

3.73 We considered whether these specific forms of conduct, and perhaps others, should be included within the scope of the remedy. We also considered whether it would be desirable to include a more general measure in the remedy, prohibiting conduct and contract terms which could be deemed to illustrate the exercise of market power.

- *Additional conduct/contract terms*

3.74 We reasoned that while more, specific forms of conduct or contract terms could be added to the remedy it was unlikely that the list would be comprehensive, or remain so for long, as hospital groups could adopt other tactics which we had not foreseen through which to exploit their market power. We therefore considered whether a more general prohibition of conduct/contract terms could be included which would prevent circumvention through the adoption of certain tactics in the future.

- *A general anti-circumvention measure*

3.75 We thought that it was inevitable that any general anti-circumvention measure would be more likely than a specific prohibition to give rise to disputes between the parties as to whether particular forms of conduct or contract terms fell within the scope of the remedy. Various parties, including the OFT, had suggested that to be effective the remedy, even as originally envisaged, would need to be accompanied by a mechanism or process for resolving such disputes.

- 3.76 We noted that dispute adjudication mechanisms had been adopted as remedies in several CC market or merger inquiries.<sup>301</sup> We also noted that relationships between PMIs and hospital operators appeared, generally, to be characterized by distrust, disagreements and disputes. We therefore considered whether an adjudication process or dispute resolution process would be necessary or appropriate to ensure the effectiveness of this remedy.
- 3.77 In previous remedies where we have required the creation of an adjudicator we have been able to specify fairly precisely what conduct was considered to fall within the scope of the measure. We thought that, although it would be feasible to require an adjudicator to decide whether particular contract terms fell within the scope of a specific prohibition, it would go beyond the scope of an adjudicator to do so when the criteria for adjudication were less precise and where it might be necessary to exercise a high degree of judgement. We noted earlier, for example, that a hospital operator could adopt a very wide range of tactics to deter a PMI from recognizing a competitor, including refusal to participate in a new network being contemplated by an insurer. It would be extremely difficult to demonstrate that such conduct was linked to a dispute over hospital recognition. We thought that ruling in such cases would more closely resemble the role of a regulator than an adjudicator. We consider this issue further when we discuss proportionality.

- *Conclusions on effectiveness*

- 3.78 In order for Remedy 2(a) to be fully effective it would be necessary to identify a comprehensive and specific list of forms of conduct or contract terms to be prohibited. However, we considered it likely that parties would be likely to circumvent the remedy by adopting additional forms of conduct that would fall outside the scope of

---

<sup>301</sup> These include, in merger inquiries, the Office of the Adjudicator (CRR) and the Office of the Adjudicator (Broadcast Transmission Services) and, in market investigations, the Groceries Ombudsman (GSCOP).

the remedy and which we had not foreseen or specified. To address such circumvention risks it would be necessary to adopt a more general anti-circumvention measure together with a mechanism to resolve disputes between the parties, including as to whether a particular form of conduct was prohibited under the remedy.

3.79 We consider that distinguishing between an inappropriate exercise of market power and legitimate cost-reflective volume discounts in this market is likely to be complex. In addition, a general anti-circumvention measure may detract from the clarity needed in a fully effective remedy.

3.80 We therefore consider that Remedy 2(a), even if supplemented with a general anti-circumvention measure and a dispute resolution mechanism, is unlikely to be substantially effective in addressing the relevant AEC.

3.81 We provisionally decided that Remedy 2(b) would not be effective since, while we thought that hospital operators would lower prices in competitive areas, they would seek to raise them elsewhere and would not be deterred from doing so by the threat of entry or other factors.

- *Conclusions on proportionality*

3.82 We next considered whether this remedy was reasonable and proportionate on the basis of our guidelines.<sup>302</sup>

- *Parties to whom the remedy is applicable*

3.83 We considered whether the remedy should apply to the other major hospital chains, Ramsay and Nuffield. We first considered whether their inclusion within the scope of the remedy would be reasonable.

---

<sup>302</sup> CC3, [paragraph 344](#).

3.84 The remedy is designed to address the AEC that we have provisionally found that certain private hospital operators have market power in negotiations with PMIs.

However, we had not found that Ramsay and Nuffield had market power. We therefore concluded that it would not be reasonable to include them within the scope of this remedy and that it should only apply to BMI, HCA and Spire.

- *Proportionality of the remedy in respect of BMI, HCA and Spire*

3.85 We next considered whether, if effective in addressing the AEC we had provisionally found for BMI, HCA and Spire, the remedy would be proportionate. We had previously decided that, in order to be effective, Remedy 2(a) would need to:

- (a) include additional, specific forms of conduct and contract terms that would be prohibited;

- (b) include, as an anti-circumvention measure, a more general prohibition on forms of conduct or contract terms which could be considered to indicate market power; and

- (c) be accompanied by a regime to deal with disputes arising between the parties, including those relating to forms of conduct not specified in the remedy.

3.86 We thought that the dispute resolution measures that it would be necessary to adopt to make this remedy effective would be costly, complex and go beyond the scope of adjudication arrangements that we have previously required. These typically involve an adjudicator ruling whether proposed changes to customers' contracts are compatible with a clear set of guidelines and calculations. We thought that the discretion that would need to be exercised by an adjudicator in this case would be considerably wider than in other schemes the CC had designed. This might include trying to understand the basis of a price proposal and whether it was designed to penalize a PMI or not or whether a particular, though previously unspecified, form of conduct was anticompetitive.

3.87 We provisionally decided that, if this remedy were to cover comprehensively all forms of conduct that would indicate the exercise of market power, it would need to be accompanied by a process for dispute resolution that would be expensive, complex and intrusive. We also concluded that even with comprehensive coverage the remedy is only likely to be partially effective in addressing the AEC.

- *Conclusions*

3.88 We provisionally concluded that Remedy 2(a) as currently specified would not address the AEC effectively. We thought that even if significantly expanded in scope and accompanied by an intrusive and complex oversight regime it may only do so partially. We therefore provisionally decided that it would not be appropriate for us to pursue this remedy further. For the reasons we set out here we did not consider that Remedy 2(b) would be effective and have therefore provisionally decided not to pursue it further.

### *Remedy 8 (price controls)*

3.89 In our Remedies Notice, we said that we had considered the imposition of price controls (Remedy 8) but that we did not intend to pursue this remedy further unless we were provided with evidence or reasoning as to why we should take it into account. We said that, while price control may be an effective remedy, we thought it would be complex to design and update, would require some form of adjudication in the event of disputes and would be likely to have unintended consequences, such as deterring new entry.

3.90 Bupa told us that, in its opinion, our proposed remedies did not provide effective constraint on hospitals in the significant majority of single/duopoly areas.<sup>303</sup> It did not believe that either the threat of entry or that of a CMA investigation provided any

---

<sup>303</sup> [Bupa response to the Remedies Notice](#), paragraphs 4.41–4.48.



meaningful constraint on the pricing of incumbent operators. It suggested that we should consider price control for approximately [X] single hospitals (and targeted divestment of certain duopoly hospitals, in addition to our proposed divestments in cluster areas). Bupa estimated a ballpark figure of £[X] million a year of private spend (by self-pay patients and PMIs) in these [X] hospitals and thought that this would likely outweigh the cost of enforcing a price control regime (which should be funded by the hospitals subject to the control). It said that a price control mechanism could either involve a bottom-up costing of services to construct a tariff or the price of treatments could be linked/pegged to the average price of similar treatments at a like-for-like hospital in competitive local markets, correcting for geographic cost differentials.

3.91 No other major party to the inquiry favoured imposition of a price control regime.

3.92 In our guidance,<sup>304</sup> we say that:

this type of behavioural remedy can be complex to implement and monitor, given informational asymmetries between the parties and the authorities and the associated risk of circumvention. There is also a risk that such controls create market distortions, particularly if they are kept in place over a long period. Ensuring that measures to control outcomes remain fit for purpose in the light of market developments may involve costs for monitoring and enforcement agencies as well as for the parties subject to them.

3.93 We were concerned that, given the large number of different treatments and procedures in existence, a price control regime would be very difficult and costly to set up in this market (whether in the form of a reference tariff or by comparison to charges

---

<sup>304</sup> CC3, [paragraph 378](#).

levied by similar hospitals) and to update, to take account of both the introduction of new treatments and procedures, and movements in costs over time. We were also concerned that price controls may be vulnerable to circumvention, in that hospitals subject to such a cap would be incentivized to reduce the quality of the service they provide. Further, we thought that the existence of price caps may generate distortion risks over time by discouraging innovation and the introduction of new and better treatments and procedures. They would also discourage new entry into an area subject to a capping regime, unless the potential new entrant could be certain that the fact of its entry would result in the removal of price caps in that area. There is at present no private healthcare industry regulator and the imposition of this remedy would require one to be created to administer and update the price-capping regime and adjudicate on disputes.

- 3.94 We considered that, while price caps might appear to address the immediate customer detriment in single hospital areas, the cost of setting up and administering such a regime would be considerable and, over time, would result in customer detriment through distortions creating lower quality of service and reduced innovation. While we accept that the suite of remedies which we provisionally intend to introduce does not immediately address the AECs we have provisionally found in respect of Single and Duopoly areas, we do not think that a price-capping regime would be effective in the long term, or proportionate. On balance, we thought that the private healthcare industry was not a suitable market for the imposition of this type of behavioural remedy.

## ***Other remedy proposals***

### ***Background***

- 3.95 In their submissions to us, some of the PMIs proposed other potential remedies to deal with the AECs that we had provisionally found. In this section, we describe each

proposal briefly and then go on to say why, after careful consideration, we decided not to adopt it.

#### *AXA PPP*

3.96 AXA PPP suggested<sup>305</sup> that, for a prescribed list of tests, scans and drugs (to be defined), PMIs should have the right to make their own procurement arrangements from wholesalers of these products and services. Hospitals and clinics would then be required either to charge at the same rate as that secured by the PMI or to make use of the separate wholesale arrangement made by the insurer. It said this would very significantly increase the level of price competition for these services to the benefit of the consumer. It considered that a remedy of this kind would also have significant positive effect where the remedy of divestment, in particular outside of London, had been identified as being less effective since it would drive more competition, even in those areas which remain served by a single hospital or duopoly.

3.97 While AXA PPP's proposal does address a clear area of concern, we considered that, as with Remedy 2(b), this remedy would be unlikely to address the AEC comprehensively. First, we thought that it would be extremely complex to monitor and enforce since disputes would inevitably arise over the comparability of the alternative sources found by PMIs to be cheaper than the hospitals. Some form of adjudication process would have to be created as part of the remedy and this would add to its cost. Secondly, we thought the proposed remedy presented circumvention risks. If it were introduced, and hospital operators incurred a loss of revenue as a result, we thought that they would not find it difficult to make up the lost revenue in other ways, for example by cross-subsidy from other types of charges not subject to this remedy. Finally, we were concerned about the practicability of sending patients elsewhere for scans, for example, if a hospital declined to match a PMI's negotiated rate. We

---

<sup>305</sup> [AXA PPP response to provisional findings and Remedies Notice](#), paragraph 1.27 ff.

therefore provisionally decided that AXA PPP's proposed remedy would not be effective.

#### *PruHealth*

- 3.98 PruHealth was concerned about hospital charge-master items that mainly focused on the level of markups for drugs and appliances/prosthesis, and the pricing of pathology and radiology tests.<sup>306</sup> It proposed that a reference price (not a tariff) should be defined for pathology and radiology tests. The reference price would be based on the purchase cost of the equipment/reagent, leasing/depreciation costs over seven years, insurance and maintenance costs, and a defined utilization rate.
- 3.99 PruHealth also proposed the creation of reference prices for consultants' fees, based on average costs, time and pricing.<sup>307</sup> Consultants could vary their fees above or below the reference rate, but the existence of a reference rate would at least provide self-pay patients with a basis from which to judge the reasonableness of the fees they were being asked to pay.
- 3.100 We thought that PruHealth's first proposal came close to price regulation, and would in effect require the definition of a regulated asset base for each hospital and the creation of a new regulator to enforce the remedy. We considered that the complexity and expense of monitoring and enforcing such a remedy would make it disproportionate to the harm it was intended to address.
- 3.101 We thought that PruHealth's second proposal also came close to price regulation, and would remove an element of competition among consultants. Although analogous regulations exist in other countries (such as the USA, South Africa and Canada) in respect of their public health provision, we considered that setting (and regularly

---

<sup>306</sup> [PruHealth response to the Remedies Notice](#), 'Alternative solutions to price control'.

<sup>307</sup> *ibid*, 'Consultant fees'.

renegotiating) reference prices for each and every procedure that a consultant undertakes would be complex and time-consuming, and disproportionate to the harm the remedy was intended to address.

#### *Aviva*

- 3.102 In order to make price negotiations more transparent and to provide PMIs with visibility over how hospital operators price for the services they offer, Aviva suggested that the CC consider a remedy that required hospital operators to present, for a basket of common procedures, an open-book analysis of their proposed charges.<sup>308</sup>
- 3.103 Aviva also said that consultants should share the reasons why they were recommending one hospital over another with the customer or consumer.
- 3.104 We considered that open-book pricing worked best in a context where the participants viewed each other essentially as partners and the atmosphere generally was one of cooperation rather than confrontation. We thought that the introduction of open-book pricing to negotiations between hospital operators and PMIs would inevitably lead to disputes (for example, over how prices were calculated), requiring the creation of an adjudicator to resolve them. We also thought that, to the extent that hospital groups have market power, open-book pricing might not necessarily lead to lower prices, as that power would enable them to charge significant markups over cost if they so wished.
- 3.105 We thought that our Remedy 4 which, inter alia, requires consultants to disclose any financial interest they may have in a hospital, was sufficient in terms of transparency. We did not consider Aviva's second proposal, that consultants should also provide a

---

<sup>308</sup> [Aviva response to provisional findings and Remedies Notice](#), paragraph 8.

detailed set of reasons for recommending one hospital over another, was necessary or appropriate.

#### *WPA*

3.106 WPA told us that hospital operators should be obliged to publish clear and transparent pricing information as to the cost of treatment. It said such prices should be readily available for all to view and compare at any time. Hospitals should be only able to discount from such a tariff by up to a certain level of discount, say 20 per cent (to reflect special terms or quantum). It said that, in this way, other providers, insurers and self-pay patients would be able to ascertain the likely cost of treatment within a reasonable tolerance level. WPA thought that this would create a requirement to offer realistic pricing which, in conjunction with the other remedies proposed by the CC, would bring in real competition.

3.107 We considered that limiting a hospital provider's ability to discount (eg for volume) would not foster rivalry between PMIs and would favour smaller PMIs at the expense of larger ones. We thought that it did not take sufficient account of the high level of fixed costs incurred by hospital operators, which made it rational for them to offer larger discounts to customers from whom they anticipated higher volumes of patients, for example by being included on a particular network. We also thought that the transparency objective of the proposal (ie that patients should be able to ascertain the likely cost of their treatment) could be met by our requirement in Remedy 6 that consultants disclose to patients both their own fees for consultations and the indicative cost (both surgical and anaesthetic) for the most likely procedures, whether medical or surgical, undertaken by the consultant. We were reluctant to interfere, without a very good reason, in the freedom of hospital operators and PMIs to negotiate prices between themselves and, as the transparency objective vis-à-vis

patients could be met by Remedy 6, we did not consider that the imposition of an obligation to publish tariff prices was proportionate or appropriate.

## **4. The proposed package of remedies: effectiveness and proportionality**

### ***Introduction***

4.1 Our analysis of the options and the provisional decisions set out in Sections 2 and 3 lead us to propose the following package of remedies:

*(a) Divestiture of hospitals (Remedy 1)*<sup>309</sup>

We propose that HCA should divest two hospitals in central London (London Bridge and Princess Grace) and that BMI should divest seven hospitals in various local markets across England (either Bishops Wood or Clementine Churchill, either Cavell or Kings Oak, either Shelburne or Chiltern, Chelsfield Park and either Sloane or Shirley Oaks, either Saxon Clinic or Three Shires and Highfield). Divestiture would take place to suitable purchasers that are independent of the divesting parties and have appropriate financial resources, expertise and assets to enable the divested hospitals to be effective competitors in their respective markets. Appropriate expertise would include expertise and experience in operating hospitals of a level of acuity and specialism appropriate to the hospitals being divested. We would require commitments from the divesting hospital groups not to induce consultants to move their practice to the private hospital group's retained facilities, that private medical insurers continue to recognise on the same terms the divested hospital for a period and we would require the appointment of a monitoring trustee to oversee the divestiture process and compliance with divestiture commitments. We will reserve the right to appoint a divestiture trustee should divestiture not be implemented within the specified divestiture period.

*(b) Restrictions on PPU control (Remedy 3)*

This remedy would require proposed transactions between NHS Trusts and private hospital operators for the operation of a PPU to be evaluated on a case by case basis on their merits. Parties would be required to notify such arrange-

---

<sup>309</sup> For convenience we use the remedy numbering as set out in the Remedies Notice.



ments to the OFT/CMA and the OFT/CMA would review such arrangements either under the merger control regime if they create a merger situation or under the provisions of the order. Arrangements assessed under the order would be assessed applying a competition test equivalent to the significant lessening of competition test under the UK merger control regime. The ability to review and ultimately prohibit a private hospital operator that faces weak competitive constraints in a local area from entering into arrangements to operate a PPU in that area will open up relevant local areas to entry or expansion by other providers.

*(c) Restrictions on clinician incentive schemes (Remedy 4)*

We would require this measure to take the form of an order prohibiting private hospital operators from providing incentives to clinicians which may encourage them to treat patients at or commission treatments or tests from their hospitals. It will also place constraints on equity sharing arrangements between private hospitals and clinicians and require the disclosure of other benefits or services provided by private hospitals to clinicians.

*(d) Publishing information on hospital and consultant performance (Remedies 5 and 7)*

This measure will require private hospital operators and private medical insurers to fund jointly an information organization to collect and publish information with prescribed content and format on the performance of hospitals and individual consultants.

*(e) Providing consultant fee information (Remedy 6)*

Under the proposed remedy, private hospitals would require, as a condition to practising at their facilities, that all consultants provide fee information to patients in a standard prescribed format. In the longer run, consultants would be required to submit to the information organization information on their outpatient consultation and standard procedure fees for publication on its website.

- 4.2 In the remainder of this section of the provisional decision on remedies we:
- (a) describe how the proposed package of remedies addresses the AECs and the resulting customer detriment which has provisionally been found (see paragraphs 4.3 to 4.11);
  - (b) consider the effectiveness of the package, including the extent to which the remedies are capable of effective implementation, monitoring and enforcement, the timescale over which they will take effect and the coherence of the remedies package taken as a whole (see paragraphs 4.12 to 4.33);
  - (c) consider the effect of any action on RCBs (see paragraphs 4.34 to 4.39); and
  - (d) assess the proportionality of the package (see paragraphs 4.40 to 4.50).

### ***How the proposed package of remedies addresses the AEC***

- 4.3 We discussed the rationale of each element of the remedies package in Section 2. In this section we set out how the remedies package works as a whole to remedy the AECs and the resulting customer detriment that we have provisionally found. We first discuss the individual contribution of each element of the package of remedies to remedying the AECs and then the synergies that exist between the elements.

### ***Contribution of individual elements of the remedy package***

- 4.4 The individual contributions of each element of the package are described in detail in Section 2. We summarize these here for convenience:
- Remedy 1: The divestitures that we would require HCA and BMI to make would introduce greater rivalry in some major population centres and areas of high private health insurance penetration: central and Greater London, the home counties to the north, north-west and south-east of London, and part of the North-West of England. In central London we consider that the proposed divestitures will enable substantially greater rivalry on price, quality and innovation. We consider it likely that new ownership of the London Bridge and Princess Grace hospitals will

result in lower prices together with the maintenance or improvement of standards at these hospitals given the importance of high quality care in attracting and retaining corporate clients, patients and consultants. Outside of London we envisage that the structural changes arising from the divestitures, though smaller in scale, will also result in greater rivalry, bringing benefits to the hospitals' customers in terms of price, quality and innovation.

- Remedy 3 addresses the high barriers to entry and weak competitive constraints in many local areas including central London, which are features of this market. The review by the OFT/CMA on a case by case basis of arrangements between PPUs and private hospital operators to operate PPUS will open up the market by enabling alternative providers to enter or expand in local markets in which hospitals currently face weak competitive constraints.
- Remedy 4: This remedy aims to restrict and make transparent the means by which private hospital operators compete for clinicians through incentives and thus prevents distortions in competition where these incentives might introduce non-clinical considerations into private hospital and treatment decisions. The remedy relies in some cases on the enforcement of a total ban by the OFT/CMA and in others on the disclosure of benefits in cash or kind being provided and the basis on which these are made available by private hospital operators to clinicians.
- Remedies 5, 6 and 7 together comprise a package of information measures that will make it easier for potential patients, GPs and consultants to assess a private hospital's suitability in terms of quality, as measured by a variety of relevant, understandable and comparative performance indicators, and price, via a set of disclosure requirements. It will also allow patients and GPs to assess a consultant's suitability in terms of the quality of service s/he provides and the price s/he charges. We consider that this remedy will address the AEC both by facilitating patient choice on the basis of quality and price, thus rewarding better performing

hospitals and consultants, and by stimulating hospitals and consultants to compete for patients on the basis of the publication of performance data based on objective quality criteria.

### *Synergies between remedies*

4.5 In broad terms our remedies address the AEC by:

- (a) reducing local concentration (through divestitures and by lowering barriers where feasible); and
- (b) enabling rivalry between private hospitals on the basis of the price and quality of the services they provide to patients rather than, for example, the benefits they provide to clinicians, and enabling rivalry between consultants on the basis of the price and quality of the services they provide to patients.

4.6 We do not consider that any of our proposed remedies would, in isolation, address the AECs comprehensively. For example, the controls on clinician incentives contained in Remedy 4 would not on their own solve the AEC in central London as private medical insurers and self-pay patients would still have few alternative options. The divestitures that we have proposed in central London and elsewhere, however, would similarly not address the AECs comprehensively in isolation as divesting parties might, for example, unless these were subject to scrutiny and control, be able to use a variety of inducements to attract or retain, in particular, consultants from the hospitals that it divested to the hospitals that it retained.

4.7 Remedy 3, would facilitate new entry which the existing operator could, absent Remedy 4, frustrate through the use of incentives to retain consultants at its hospital rather than practise at the PPU. Our information remedies will facilitate comparison between the services provided by the existing private hospital and the new entrant.

4.8 Even if Remedies 1, 3 and 4 were adopted, competition between private hospitals and between consultants could be stifled by the lack of objective, relevant and comparative information on the quality of the services that they provide and the fees charged by consultants. Remedies 5, 6 and 7 are designed to work alongside the other remedies in the package to assist corporate and individual customers to select appropriate private hospitals and consultants. We consider that the provision of information on the performance of private hospitals and consultants will also increase rivalry between private hospitals and between consultants by encouraging patients to, for example, weigh travel time to a private hospital against the quality of care provided. In the absence of adequate information on service quality, patients may naturally tend to choose their nearest hospital and/or a consultant who is familiar to their GP. If they were aware of quality differences between private hospitals and between consultants they may be willing to travel further to use their services. Our information remedies thus work together with our structural measures.

*Conclusion on how the proposed remedy package addresses the AEC*

4.9 In summary, we consider that our remedies will work in combination to increase rivalry between providers of private healthcare and should ensure that this increased rivalry benefits patients.

4.10 We consider that our remedy package will address the AECs that we have provisionally found arising from the structural and conduct features of the market that we identified: namely that there are high barriers to entry for full service hospitals, that there are weak competitive constraints in many local markets, and that the operation of clinician incentive schemes and lack of publicly available price and performance information distorts competition between private hospitals and between consultants.

4.11 We now turn to our assessment of the effectiveness of our proposed remedy package.

***The effectiveness of the remedies package***

4.12 Our assessment of the effectiveness of our remedy package focused on the following factors:

- (a) the means by which the remedies would be implemented, monitored and enforced;
- (b) the timescale over which our remedies would have effect;
- (c) the consistency of our remedies with other regulatory regimes; and
- (d) the coherence of our remedies as a package.

***Implementation, monitoring and enforcement***

4.13 In developing our remedy options we considered how each of them could best be implemented, monitored and enforced. Our provisional decision on how each measure should be implemented and our reasoning is set out in Section 2.

4.14 We considered, where we were intending to take action ourselves rather than to make a recommendation to others to take action, whether we should seek undertakings from the relevant parties or make an order. We took into account the extent to which our proposed remedies fell within our order-making powers as well as the practicalities of negotiating undertakings with the number of parties from which it would be necessary to seek undertakings.

4.15 In accordance with our guidance, where it appeared that a proposed remedy fell within our order-making powers, we considered whether the way our remedies were intended to operate and their implications would be clear to the persons to which they

were directed and to other interested persons, including sectoral regulators and the OFT/CMA.<sup>310</sup>

4.16 We considered the cost and complexity of monitoring and enforcing our remedies. Where options appeared to exist, as with Remedy 3, between Monitor and the OFT/CMA, we considered which body would be the most appropriate to implement, monitor and enforce a remedy or whether a new body would need to be created to do so.

4.17 Based on the above considerations and our detailed assessment of each remedy set out in Section 2, we provisionally conclude that our remedies package is capable of effective implementation, monitoring and enforcement.

#### *Timescale over which our remedies will have effect*

4.18 In considering the timescale over which our remedies will have effect we took account of the time that it is likely to take to implement the remedies and, once implemented, the time it is likely to take for them to have effect.

#### *Orders*

4.19 We anticipate that the orders through which the majority of our remedies will be implemented will be made within a period of around six months from the publication of our final report, ie by October 2014. This takes into account both the consultation on draft orders and the Government's suggested common commencement dates of 6 April or 1 October for new legislation and regulations, aimed at minimizing burdens on business.<sup>311</sup>

---

<sup>310</sup> CC3, paragraph 334.

<sup>311</sup> Common Commencement Dates, BIS.

- 4.20 In the case of divestitures, we intend to allow the parties a maximum period of [X] for the initial divestiture period. The likely end date for the initial divestiture period would thus be [X] though this could be later, if the process of making the order is delayed, or sooner, if the parties commenced the sales process before the order was made. We intend also to require HCA and BMI to appoint, as early as is practicable, a monitoring trustee to mitigate asset risk at the hospitals to be sold.
- 4.21 In addition, we are proposing that hospital agreements (on recognition and terms) with private medical insurers are rolled on for a period of 18 months after divestiture, though this might be varied by mutual consent, potentially introducing the price reductions that should result from greater rivalry sooner.
- 4.22 As regards clinician incentives we considered it would be reasonable to make a distinction between those schemes which will be subject to an outright prohibition and those where current arrangements will need to be modified or abandoned to comply with our order.
- 4.23 In the former case we concluded that the prohibition should come into effect immediately on implementation of the order since such schemes are the most likely to distort competition between hospitals, have become increasingly rare since the start of the original OFT investigation and subsequently our investigation, and in many cases would appear contrary to the GMC's Good Medical Practice. Other schemes, including those involving shared equity and joint ventures between private hospital operators and clinicians are liable to be more complex to deal with and take longer to unwind or amend. Given that the CC's intentions will be made clear in its final report we thought it would be reasonable to set a deadline for this of April 2015, ie six months after the likely making of the order and 12 months after the publication of our final report.



4.24 The time that it will take for our information remedies to have effect will vary. It should be possible for the remedy requiring private hospital operators to ensure that consultants with practising rights at their hospitals provide patients with written fee information in advance of treatment to come into effect immediately. The remedies requiring the collection and publication of private hospital and consultant performance will take longer and will in any case build up gradually. We have set out an indicative timescale for the staged implementation of the private hospital and consultant performance indicators in Section 2.

### *Consistency with other regulatory regimes*

4.25 We considered the consistency of each of our proposed remedies with other relevant regulatory regimes. Our consideration is set out in the description of the individual remedies in Section 2 and we summarize it here.

4.26 We considered whether our Remedy 3 was compatible with EU procurement rules. Our view was that EU procurement rules were intended to ensure a competitive tender, leading to best value for money, but that they could not be used to override competition law or merger control, and that NHS Trusts would not be required by EU procurement law to make a contract award which gave rise to an AEC (or SLC). We therefore concluded that our remedy was compatible with EU procurement law.

4.27 We also considered whether Remedy 3 was consistent with the provisions of merger control, as the test we have proposed for our remedy would be similar to that used in UK merger control, even though arrangements which create a merger situation will be excluded from the scope of Remedy 3.

4.28 We concluded that the test proposed for Remedy 3 would remedy arrangements which were outside merger control in a way which both remedied the AECs we found

in our Provisional Findings, and was consistent with the outcome that could be expected had the arrangements been a merger, subject to merger control.

- 4.29 Finally, we considered whether our Remedy 4 on clinician incentives was inconsistent or incompatible with the GMC's Good Medical Practice. We concluded that, while our remedy is aimed at private hospital operators rather than clinicians, the principles set out in Good Medical Practice are fully compatible and consistent with those of our proposed remedy.

### *Coherence as a package*

- 4.30 As we set out in paragraphs 4.6 to 4.8, the remedies in our package work together to address the AECs that we have provisionally found. None in isolation would be fully effective but in combination will address the AECs so far as is reasonable and practicable.

### *Conclusion on effectiveness of remedy package*

- 4.31 Based on the assessment set out in paragraphs 4.12 to 4.17 we provisionally concluded that this package of remedies would be effective in addressing the AECs that we have provisionally identified and, as a result, would also substantially reduce the customer detriment flowing from the AECs.
- 4.32 We expect the remedy package to have a substantial effect on the AECs and resulting detriment within two to three years, particularly in central London, as a new competitor or competitors emerge(s). Our information remedies, however, may take longer to affect patient and GP behaviour, as they become familiar with them over time. We anticipate, however, that the publication of comparative private hospital and consultant performance information will have a more immediate effect both on hospital operators, corporate clients, private medical insurers and consultants.

### ***Relevant customer benefits***

- 4.33 In deciding the question of remedies the CC may also have regard to the effect of any action on any RCBs of the feature or features of the market concerned.<sup>312</sup>
- 4.34 RCBs are limited to benefits to relevant customers in the form of:
- (a) lower prices, higher quality or greater choice of goods and services in any market in the UK; or
  - (b) greater innovation in relation to such goods and services; and
  - (c) a benefit is only an RCB if the CC believes that the benefit:
    - (i) has accrued as a result of the features concerned; and
    - (ii) was or is unlikely to accrue without the features or features concerned.<sup>313</sup>
- 4.35 We considered whether there were any RCBs that we should take account of in formulating our remedies. In discussing the divestiture remedy (Remedy 1) we considered whether proposed divestitures would reduce or extinguish potential RCBs and concluded that they would be unlikely to do so (see paragraphs 2.126 to 2.138 and Appendix 2.1 on central London).
- 4.36 We have not identified any other potential RCBs deriving from the features identified in our Provisional Findings that would be extinguished by either one of our remedies in isolation or by the remedies in combination.

### ***Assessment of proportionality***

- 4.37 We evaluated whether this package would be a reasonable and proportionate solution to the AECs by considering the following four questions:
- (a) Is the remedy package effective in achieving its aim?

---

<sup>312</sup> The Act, section 134(7).

<sup>313</sup> CC3, [paragraphs 356 & 357](#).

- (b) Is the remedies package no more onerous than is necessary to achieve its aim?
- (c) If there is a choice of remedy packages, is this the least onerous?
- (d) Does the remedy package produce adverse effects which are disproportionate to the aim?

*Is the remedy package effective in achieving its aim?*

4.38 As we have set out in paragraph 4.12 above we consider that this remedy package will be effective in addressing the AECs that we have provisionally identified.

*Is the remedy package no more onerous than is necessary to achieve its aim?*

4.39 Some parties have submitted that very intrusive remedies are required, including the regulation of hospital prices. We have endeavoured to formulate a package of measures likely to facilitate competition rather than replace it with a regulatory regime. In our provisional findings we identified, for example, 101 hospitals which we characterized as facing insufficient competitive constraints. Many of these were in what we described as ‘Single’ or ‘Duopoly’ areas where, clearly, divestiture would be ineffective as a remedy since it would simply transfer market power from one operator to another. We addressed our competitive concerns in such areas by adopting much less intrusive remedies than those potentially available, such as price control, aimed at increasing rivalry by lowering entry barriers and increasing transparency.

4.40 Where we have adopted intrusive remedies, such as divestiture, we have sought to ensure that the divestiture package concerned is the smallest required to address the AECs. Several parties urged us to adopt a much broader divestiture package of hospital and other assets in central London, for example. Similarly, in Remedy 3, we have made provision for the clearance of arrangements likely to increase local concentration if no other candidate to manage a PPU has emerged.

*If there is a choice of remedy packages, is this the least onerous?*

- 4.41 We set out in Section 3 remedies that we proposed ourselves or which have been proposed by others that we have considered but have decided not to pursue. As is described there, in some cases, for example Remedy 2(a), we decided not to pursue a remedy any further since in order to make it effective it would have been necessary to specify it in such a way as to render it disproportionate, for example by creating what would amount to a sector regulator.
- 4.42 We also consider that all of the remedies in this package are necessary to its effectiveness since they work on aspects of the AECs in different, though complementary, ways. From our analysis and the views of parties to this inquiry, it is not apparent that any other package of remedies would be as effective whilst incurring similar or lower costs on the market.

*Does the remedy package produce adverse effects which are disproportionate to the aim?*

- 4.43 We first considered costs that might arise from the remedies in our package.
- 4.44 We invited parties to tell us what costs, to them and others, would be likely to arise as a result of each of our remedies. We considered these submissions carefully and in Section 2 we set out, for each individual remedy, what parties had told us together with our assessment of what they had said.
- 4.45 We estimate that the quantifiable benefits (ie price benefits) to customers likely to arise from the divestiture remedies would be in the range of £13.9 million to £18.6 million *per year* and the costs, which are all one-off, to be in the region of £22 million (on our base case). We estimated that the net present value of our divestiture remedies was, therefore, approximately £187 million over a 20-year

period.<sup>314</sup> In addition, we considered that there were likely to be other benefits in terms of quality and innovation that would be significant over time but could not be readily quantified.

4.46 We also quantified the likely incremental costs of our information remedies, which we estimated at between £7 million and £8 million a year. As set out in paragraphs 2.484, 2.487 and 2.534, we did not seek to quantify the likely quality and/or innovation benefits since we did not consider that these benefits were amenable to quantification. However, we judged that these benefits could be expected to be material in light of previous experiences of the impact on quality resulting from the publication of performance data.

4.47 The benefits of remedies in our proposed package other than divestiture are discussed individually in Section 2. We consider that although these benefits are difficult to assess quantitatively, they are likely to be significant over time and substantially in excess of the costs associated with them.

#### *Conclusions on proportionality of remedies package*

4.48 We consider that the proposed remedies package fulfils all four conditions for proportionality set out in our guidance.

#### ***Conclusions on the remedy package***

4.49 We have provisionally decided that we should introduce the package of remedies summarized in paragraph 4.1.

---

<sup>314</sup> This figure refers to our base case estimate. Our downside case indicates an NPV of approximately £57.5 million, while our HCA upside case indicates an NPV of between £294 million and £365 million for the HCA divestitures alone.

4.50 In our judgement this represents as comprehensive a solution as is reasonable and practicable to the AECs and resulting customer detriment that we have provisionally found.