

PRIVATE HEALTHCARE MARKET INVESTIGATION

Notice of possible remedies under Rule 11 of the Competition Commission Rules of Procedure

Introduction

1. On 4 April 2012, the Office of Fair Trading (OFT) in exercise of its powers under sections 131 and 133 of the Enterprise Act 2002 (the Act), made a reference to the Competition Commission (CC) for an investigation into the supply or acquisition of privately funded healthcare services in the UK.
2. The CC is required to determine whether any feature or combination of features of each relevant market prevents, restricts or distorts competition in connection with the supply or acquisition of any goods or services in the UK or a part of the UK.¹ If the CC decides that there is such a prevention, restriction or distortion of competition, there will be an 'adverse effect on competition' (AEC).²
3. In its provisional findings, a summary of which was published on 28 August 2013, the CC has provisionally found AECs and in Section 10 of the provisional findings identifies those features that the CC provisionally finds give rise to the AECs and the resulting detrimental effects on customers.
4. Where the CC finds that there is an AEC, it has a duty to decide whether it should take action and/or whether it should recommend others to take action to remedy, mitigate or prevent the AEC or any resulting detrimental effects on customers.³ If the CC decides that such action is appropriate it must also decide what action should be taken and what is to be remedied, mitigated or prevented. In deciding these questions the CC has a duty to achieve as comprehensive a solution as is reasonable and practicable to the AEC and any resulting detrimental effects on customers.
5. This Notice of possible remedies (Notice) sets out and invites comments on possible actions which the CC might take in order to remedy, mitigate or prevent the AEC or any resulting detrimental effects on customers. Prior to deciding what, if any, action should be taken and by whom, the CC will take into account all comments received in response to this Notice and consult further. The parties to this investigation and any other interested persons are requested to provide any views in writing, including any suggestions for additional or alternative remedies that they wish the CC to consider, by 20 September 2013.

Features which give rise to an AEC in the private healthcare market

6. We have provisionally concluded that there are features which in combination give rise to AECs in the market for privately funded healthcare. These features are:
 - (a) high barriers to entry for full service hospitals;
 - (b) weak competitive constraints in many local markets including central London;

¹ See section 134(1) of [the Act](#).

² As defined in section 134(2) of [the Act](#).

³ Section 134(4) of [the Act](#).

- (c) the existence of incentive schemes operated by private hospital operators to encourage patient referrals for treatment at their facilities;
- (d) lack of sufficient publicly available performance information on consultants; and
- (e) lack of sufficient publicly available information on private hospital performance.

Detrimental effects

7. Together the features described in paragraph 6 (a) and (b) 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 insurers.⁴
8. We have produced an initial estimate of the detriment resulting from the market power of the private hospital operators using our profitability analysis. This analysis was based on the private hospital activities of the relevant firms,⁵ including their provision of services to NHS patients. As services to NHS patients are outside the scope of our reference, we have sought to exclude them from our estimate of detriment. Our estimate apportions EBIT and capital employed between NHS and private work in proportion to the revenue earned from each source. We then calculate the difference between the ROCE and the cost of capital (taken to be 10 per cent).
9. On this basis, our initial estimate of the consumer detriment caused by the market power of HCA, BMI and Spire is between £173 million and £193 million a year between 2009 and 2011, which is equivalent to around 10 to 11 per cent of the private revenues of these operators. We consider that this represents a conservative estimate of the consumer detriment for the following reasons:
 - (a) NHS revenue generates a lower margin than private revenue, hence a larger proportion of EBIT will relate to private patients than we have estimated in our analysis;
 - (b) we have used a cost of capital of 10 per cent, which is above the upper end of our range of 9.9 per cent, reducing the overall estimate of detriment as compared with a figure based on the mid-point of 8.6 per cent;
 - (c) the analysis does not take into account the efficiency of the operators; to the extent that less efficient operators are making a lower ROCE, this inefficiency will not be reflected in our estimate of detriment; and
 - (d) we believe that our profitability estimate may have been reduced by the economic recession in the UK.

Criteria for consideration of remedies

10. When deciding whether any remedial action should be taken and, if so, what that action should be, the CC will consider how comprehensively the possible remedy options—whether individually or as a package—address the AEC and/or its resulting

⁴ Provisional Findings paragraph 10.3.

⁵ These were Bupa Cromwell Hospital, BMI, HCA, Nuffield, Ramsay, Spire and TLC.

detrimental effects on customers, and whether they are reasonable and practicable.⁶ The CC will assess the extent to which different remedy options are likely to be effective in achieving their aims, including whether they are practicable and when they are likely to have effect.⁷ The CC will be guided by the principle of proportionality in ensuring that it acts reasonably in making decisions about remedies. The CC will therefore assess the extent to which different remedy options are proportionate, and in particular it will be guided by whether a remedy option:

- (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.⁸

11. The CC may also have regard to the effects of any remedial action on any relevant customer benefits arising from a feature or features of the market giving rise to the AEC.
12. In the event that the CC reaches a final decision that there is an AEC, the circumstances in which it will decide not to take any remedial action are likely to be rare but might include situations in which no practicable remedy is available, where the cost of each practicable remedy option is disproportionate to the extent that the remedy option resolves the AEC, or where relevant customer benefits accruing from the market features are large in relation to the AEC and would be lost as a consequence of any appropriate remedy.⁹

Possible remedies on which views are sought

13. In this Notice we describe remedy options that we have considered and believe could be effective in addressing the AEC or its detrimental effects on customers. We describe each of these remedy options in turn, explaining the feature(s) they are meant to address and how they are intended to work. Although some of our remedy options may increase the prospect of entry and expansion we could identify none which would directly address barriers to entry. We invite views on specific issues that we raise in this Notice as well as any other issues that the parties to the investigation and other interested parties would like to put to us.
14. We have distinguished in this Notice between those remedies which we currently believe may be appropriate (ie effective and proportionate) and one, a price control, which we currently believe would not be. At this stage we are only minded to consider further those remedies in the first category but we will consider further the remedy in the second category and other proposals if parties are able to provide relevant evidence and reasoning as to why these alternatives would be appropriate.
15. We first set out, in paragraphs 16 to 63, those remedies which we currently believe may be effective and which we are therefore considering further. We invite views on the effectiveness and proportionality of these measures and on the most appropriate means of specifying and implementing them. We then set out in paragraphs 81 to 84 our reasoning regarding a price control which we currently believe is not likely to be

⁶ [Guidelines for market investigations](#), CC3 Revised, paragraph 330.

⁷ *ibid*, paragraphs 327 & 330.

⁸ *ibid*, paragraphs 335–337.

⁹ [Guidelines for market investigations](#), CC3 Revised, paragraphs 355–369.

effective and/or proportionate and which, therefore, we are not currently minded to explore further.

Remedy options that we are exploring

16. We set out below possible remedies to address the features set out in paragraph 6 above that we have provisionally concluded give rise to AECs.

Weak competitive constraints in many local markets, including central London

17. In this section, we consider remedy options that may be appropriate to address the weak competitive constraints that we have provisionally found to be a feature of this market. We first set out our consideration of structural (divestiture) and behavioural remedies in turn.

Structural remedies

18. As an introduction to our consideration of possible divestiture remedies, we set out some general considerations regarding divestiture.

General considerations regarding divestiture remedy options

19. The aim of divestiture in market investigations will generally be 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).¹⁰
20. 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 rivalry resulting from structural features of a market and will generally not require detailed ongoing monitoring beyond the completion of the disposal of the business or assets in question.¹¹
21. 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.

¹⁰ [Guidelines for market investigations](#), CC3 Revised, paragraph 372.

¹¹ [Guidelines for market investigations](#), CC3 Revised, paragraph 373.

(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 divestiture business does not degrade prior to divestiture.¹²

Consideration of divestiture remedies in this case

22. We provisionally concluded that it is a feature of this market that there are weak competitive constraints in many local markets. We first consider in what circumstances a divestiture remedy would, and would not, be appropriate.
23. Weak competitive constraints may arise in two different situations. 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.
24. Alternatively, a local area may be served by one hospital or by two hospitals with different operators. For convenience, and for the purposes of this Notice, we refer to these as ‘Single’ and ‘Duopoly’ areas respectively.
25. We did not consider that divestiture in Single or Duopoly areas would be an effective remedy since, in both cases, divestiture would replace one rival with another rather than introduce more rivalry. A divestiture remedy would, therefore, only be appropriate in those areas where we have competition concerns in which Clusters of hospitals are owned by the same operator.
26. We set out our proposed approach to identifying areas in which divestitures may be effective in the Appendix of this Notice. Our preliminary analysis, based on this proposed approach, identifies slightly fewer than 20 such divestitures. This analysis will be disclosed to the five largest hospital operators and the two largest PMIs.

Remedy 1—Divestiture of one or more hospitals and/or other assets in areas where competitive constraints are insufficient

- *How the remedy would work*

27. In local areas where we have identified competition concerns (other than Single or Duopoly areas) the relevant hospital operator would be required to divest to a suitable purchaser, through an effective divestiture process, one or more hospitals and other assets it would be appropriate to include in the divestiture package in order to address the AEC.
28. In determining the appropriate scope for a divestiture package the CC would aim to ensure that it was no wider than would be necessary to address the AEC effectively.
29. The CC would specify, though not necessarily disclose, the duration of the period during which the parties should achieve effective disposal of the divestiture package to a suitable purchaser (ie the ‘initial divestiture period’.)

¹² Further information about the CC’s approach to the design and implementation of divestiture remedies in market investigations may be found in the Guidelines ([Annex B](#), paragraphs 3–30).

30. We set out the divestiture options that we are considering below, first those in central London and then those elsewhere in the UK.
- *Central London*
31. The AEC related to insured patients¹³ in central London has arisen as a result of HCA's ownership of eight hospitals and other facilities¹⁴ which between them account for [X] per cent of admissions to acute private hospitals in central London. HCA's closest rival in central London, the London Clinic, has a share of admissions of [X] per cent.
32. The remedy would require HCA to divest a hospital or hospitals and other assets (the divestiture package) to a suitable purchaser or purchasers sufficient to impose a competitive constraint on HCA's remaining hospitals in central London. In considering the scope of the divestiture package that would be necessary to address the AEC our analysis took into account the range of the services provided by each of HCA's hospitals, their customer base, the volume of their private admissions and their turnover. Our proposed approach to analyzing the divestiture package options is set out in the Appendix of this Notice.
33. We set out below a series of questions regarding the divestiture remedy proposed for central London.
- *Issues for comment 1, central London*
34. We invite responses to the following questions:
- (a) Would a divestiture remedy address the AEC in central London effectively and comprehensively? Are the criteria that we have set out for specifying a divestiture package appropriate? If not, what criteria should we use to specify the divestiture package and what assets should be included in it?*
 - (b) Are there suitable purchasers available with the appropriate expertise, commitment and financial resources to operate and develop the divestiture business as an effective competitor without creating further competition concerns? Would the remedy be effective only if the entire package were divested to a single owner or would ownership of the divested business by two or more purchasers address the AEC effectively?*
 - (c) Would a divestiture remedy on its own be sufficient to address the AEC or would additional measures be required to ensure a comprehensive solution? Would, for example, the remedy be liable to circumvention through arrangements with consultants that would result in them conducting their private practice wholly or predominantly at HCA's remaining hospitals? Are there other ways in which HCA could circumvent a divestiture measure?*
 - (d) Are there other assets or businesses, besides hospitals and their out-patient facilities, which it would be necessary or appropriate to include within a divestiture package? These could be physical assets, such as consulting rooms, or, for example, they could be joint ventures with others or NHS contracts to operate PUs. Would divestiture of any such assets or businesses present particular problems?*

¹³ See Provisional Findings paragraph 6.294(b) and 10.3.

¹⁴ These principally comprise of outpatient treatment and diagnostic centres.

- (e) *Would divestiture of an HCA hospital or hospitals and/or other assets confer market power on the acquirer? In what circumstances might this risk arise? Are there hospitals or other assets whose divestiture would be particularly likely to give rise to this risk?*
- (f) *How long should HCA be given to effect the sale of the divestiture package? Our guidelines¹⁵ state that in relatively straightforward divestiture cases a maximum period of six months is appropriate. Is that sufficient in this case?*
- (g) *What are the relevant costs and benefits that we should take into account in considering the proportionality of the divestiture options?*
- (h) *Are there other remedies that would be as effective in remedying the AEC that would be less costly or intrusive?*

- *UK, outside central London*

- 35. The AEC related to insured patients¹⁶ in local areas in the UK outside central London has arisen as a result an insufficiency of competitive constraints on BMI's and Spire's facilities in certain local areas. In these areas, BMI and Spire have large shares of the local market.
- 36. The remedy would require BMI and Spire to divest one or more hospitals (the divestiture package) in those local areas with Clusters to a suitable purchaser. In considering the scope of the divestiture package we have taken into account the nature of the services provided by the hospitals, their location, their mix of patients and their volume of private admissions. Our proposed approach to analyzing the remedy package options is set out in the Appendix to this Notice.
- 37. We set out below a series of questions regarding the proposed divestiture remedy for local areas outside central London.

- *Issues for comment, 1, outside central London*

- 38. We invite responses to the following questions:
 - (a) *Would a divestiture remedy address the AEC effectively and comprehensively? Are the criteria that we have set out for specifying a divestiture package appropriate? If not, what criteria should we use to specify the divestiture package and what assets should be included in it?*
 - (b) *Are there suitable purchasers available with the appropriate expertise, commitment and financial resources to operate and develop the divested hospitals as effective competitors without creating further competition concerns?*
 - (c) *Would a divestiture remedy on its own be sufficient to address the AEC or would additional measures be required to ensure a comprehensive solution. Would, for example, the remedy be liable to circumvention through arrangements with consultants that would result in them conducting their private practice wholly or predominantly at the divesting hospital operator's remaining hospitals? Are there other ways in which BMI or Spire could circumvent a divestiture measure?*

¹⁵ [Guidelines for market investigations](#), CC3 Revised, Annex B, paragraph 27.

¹⁶ See Provisional Findings paragraph 6.294(b) and 10.3.

- (d) *Are there other assets or businesses, besides hospitals and their outpatient facilities, which it would be necessary or appropriate to include in a divestiture package? These could be physical assets, such as consulting rooms, or, for example, they could be joint ventures with others or NHS contracts to operate PPU's. Would divestiture of any such assets or businesses present particular problems?*
- (e) *Are there particular assets whose divestiture would confer market power on the acquirer? To avoid creating further competition concerns would it be necessary to exclude certain assets from the sale?*
- (f) *How long should BMI and Spire be given to effect the sale of the divestiture package? Our guidelines¹⁷ state that in relatively straightforward divestiture cases a maximum period of six months is appropriate. Is that sufficient in this case?*
- (g) *What are the relevant costs and benefits that we should take into account in considering the proportionality of the divestiture options?*
- (h) *Are there other remedies that would be as effective in remedying the AEC that would be less costly or intrusive?*

Behavioural Remedies

Remedy 2—preventing tying or bundling

- *How the remedy would work*

39. We provisionally found that BMI, HCA and Spire have market power in negotiations with PMIs.¹⁸
40. The aim of this remedy is to prevent BMI, HCA and Spire from using their market power in certain local areas. We considered two variants of this remedy.
41. The first, (2a), would seek to prevent BMI, HCA or Spire from raising its prices nationally if a PMI changed its network policy such that patient volumes to the hospital operator concerned were likely to fall. This might 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. In neither case would the private hospital operator be entitled to raise its prices nationally in response.
42. This variant of the remedy might be appropriate for a PMI that had an existing agreement with a hospital operator and wished to retain these contractual rights but wished to vary the composition of its hospital network.
43. Were it to pursue this remedy the CC would need to be confident that it would be practicable and not prone to circumvention risks. The remedy would not remove the hospital operator's market power but seek to limit its ability to exercise it. The hospital operator might therefore be able to exercise this power in other ways, for example by structuring volume discounts in such a way as to make removing incumbent hospitals from its network, or recognizing a local rival, unattractive. We set out below some questions on which we invite responses from interested parties.

¹⁷ [Guidelines for market investigations](#), (CC3, Revised) Annex B, paragraph 27.

¹⁸ See Provisional Findings paragraph 6.248(a) and 10.3.

- *Issues for comment 2a*

44. We invite responses to the following questions:

- (a) *Would this remedy be effective? Would hospital operators be able to deter PMIs from removing hospitals from their network or recognizing a local rival in ways other than by raising or threatening to raise prices in response?*
- (b) *How quickly would this remedy come into effect? Would it be necessary to wait until existing contracts with PMIs had come to an end to implement it or could this process be accelerated, and if so how?*
- (c) *Is the remedy reasonable? Might a hospital operator have appropriate grounds for seeking a price increase from a PMI in the event that it reduced the amount of business it did with the operator? What economic rationale would there be for a cross-operator (rather than single hospital) volume discount, for example?*
- (d) *Would it be necessary to provide for continuous monitoring of the remedy and/or to establish a mechanism for adjudication in the event of disputes? If it would, which would be the most appropriate body to undertake these functions and how should it be funded? What would be the expected costs of monitoring?*
- (e) *What other measures would be necessary to prevent circumvention of the objectives of this remedy?*

45. The second variant of this remedy (2b) would be to require BMI, HCA and Spire to offer and price their hospitals separately.

- *How the remedy would work*

46. This remedy would require BMI, Spire and HCA to offer and price their hospitals separately and individually to PMIs. It rests on the assumption that in these circumstances the hospital operator would charge lower prices in competitive areas but would either raise them elsewhere (thus encouraging new entry) or be deterred from doing so by the threat of new entry or by reputational risk and would accept lower margins overall.

47. Were the CC to pursue this remedy it would need to be satisfied that it was practicable, effective and not subject to circumvention risks.

48. Issues of practicability seem more likely to arise for BMI and Spire than for HCA, because of the larger number of hospitals that they operate and the amount of work therefore entailed in negotiating prices on an individual hospital basis. We would need to be confident that the negotiating costs entailed in separately pricing hospitals would not render the process unviable for either the hospital operators or PMIs.

49. We would also need to be confident that this remedy was not subject to the circumvention risks that we set out in the context of remedy 2a.

- *Issues for comment 2b*

50. We invite responses to the following questions:

- (a) *Would this remedy be practicable? Would the scale and complexity of negotiating prices on an individual hospital basis be sustainable?*

- (b) *How quickly would this remedy come into effect? Would it be necessary to wait until existing contracts with PMIs had come to an end to implement it or could this process be accelerated, and if so how?*
- (c) *If practicable, would it be effective? To what extent could reputational risk be relied upon to deter price increases in Single hospital areas?*
- (d) *If prices were raised in Single hospital areas how confident could we be that this would lead to new entry and over what time period? Would this depend on the size and attractiveness of the local market concerned, for example the number of PMI subscribers or corporate scheme members in the hospitals' catchment areas?*
- (e) *Is it likely that this remedy would have unintended consequences? For instance, would it be likely to lead hospital operators to close hospitals and if they did would this result in consumer detriment?*
- (f) *Would hospital operators be able to frustrate the aims of the remedy by entering into arrangements with consultants that would prevent or deter them from practising at an entrant's hospital? Could hospital operators deter or delay PMIs' recognition of an entrant?*

Single and duopoly hospital areas

- 51. As noted in paragraphs 23 to 25 above, the areas where we have provisionally identified competition concerns fall into two categories. In the first, there may be several hospitals in a local area that are wholly or predominantly operated by one operator ('Clusters'). Alternatively, a local area may be served by just one hospital or by two hospitals owned by different operators (Single or Duopoly areas). We have explained why we consider that a divestiture remedy would not be effective in Single or Duopoly areas.
- 52. We considered whether our behavioural remedy 2 (either variant) would be effective in addressing the AEC in these areas. We thought that it could be only if the Single hospital was part of an operator where bundling or tying was a likely strategy.
- 53. On the other hand, if tying or bundling was unnecessary, for example if all the operator's hospitals were in Single or Duopoly areas, this remedy would not be effective. We therefore considered two further remedies:
 - (a) a restriction on further expansion in Single or Duopoly areas;
 - (b) a price control.

Remedy 3—restrictions on expansion

- 54. Here we consider a remedy option which may mitigate the AEC in Single or Duopoly areas by preventing an incumbent hospital operator from expanding through a partnership or other business agreement with a PPU.
- 55. We have provisionally found that barriers to entry are high in the private healthcare market, including that it is difficult for an entrant or a provider of outpatient and day-case services to provide inpatient services because of the scale economies involved. Because PPUs are generally co-located with NHS hospitals and thus have access to

their infrastructure and support facilities, partnering with a Trust may offer a low-risk means of market entry for hospital operators.

- *How the remedy would work*

56. This remedy would work by preventing the owner of a hospital in a Single or Duopoly area from partnering with an NHS Trust to operate a PPU. Measures to implement this remedy would be directed at hospital operators in the areas of concern that we have identified.

- *Issues for comment 3*

57. We invite responses to the following questions:

- (a) *Would the remedy be effective? In how many and which Single or Duopoly areas is it likely that PPUs will be launched?*
- (b) *How practicable would it be for other hospital operators to form PPU partnerships in areas where they did not already operate a hospital?*
- (c) *Would the remedy give rise to unintended consequences or distortions? Would NHS Trusts suffer because they would be unable to partner with an incumbent hospital operator which could offer a financially more attractive arrangement than an entrant?*
- (d) *Would customer detriment arise if the incumbent was prevented from partnering in a PPU but no entrant appeared?*
- (e) *What provisions would need to be made for oversight and enforcement of this remedy and which body should be responsible? Would it, for example, fall within Monitor's remit?*

The existence of incentive schemes operated by private hospital operators to encourage patient referrals for treatment at their facilities

58. We have provisionally concluded that the existence of incentive schemes operated by private hospital operators which encourage patient referrals for treatment at their facilities, whether in cash or kind and whether related to the value of referrals or not are a feature of the market which gives rise to an AEC. We also provisionally concluded that equity ownership by consultants of private health facilities is a feature that 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.
59. We distinguished between schemes which provide a short-term reward whose value will be directly affected by the conduct of an individual consultant, for example fee per referral schemes, and longer-term incentives, for example equity participation schemes, whose value will depend on the conduct of the generality of participants in the scheme. We noted that all such schemes have the potential to distort competition between private hospitals but that certain equity partnerships between hospital operators and consultants appeared to lower the entry barriers that we identified in our provisional findings and therefore were at least as beneficial to competition as any distortion is harmful.

60. We considered whether, within the set of schemes which gave rise to an AEC,¹⁹ these two types of scheme (short-term and long-term) should be subject to different remedies. However, we concluded that it would be very difficult to draw a clear distinction between the two types of scheme: a shareholding by a small number of consultants in a specialist clinic, for example, could mimic the effects of a fee per referral type scheme. We concluded that private hospital operators should be precluded from entering into either type of scheme.

Remedy 4—preventing hospital operators from offering to consultants any incentives, in cash or kind which are intended to or have the effect of encouraging consultants to refer patients to or treat them at its hospitals 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.

- *How the remedy would work*

61. Private hospital operators would be prohibited from offering consultants any cash or non-cash incentives to encourage them to undertake work at their facilities. This would permit private hospitals to make certain facilities, for example consulting rooms, available only if they could not be deemed to constitute an incentive to the consultant to bring work to the hospital operator, for example if it could be demonstrated that they were being charged a fair market price.
62. For the avoidance of any doubt, the CC would interpret this measure as prohibiting such arrangements even if they included caveats obliging the consultant to comply with GMC guidelines or state that the agreement imposed on the consultant no obligations to refer patients to or treat them at the hospital operator's facilities.

- *Issues for comment 4*

63. We invite responses to the following questions:

- (a) *Is the remedy practicable? What framework of rules could be used to determine reasonably and practically whether the benefits of an incentive scheme in terms of lowering barriers to entry, outweighed the distortions created? What degree of oversight would be required to monitor compliance and who should fund it and exercise monitoring? How could the 'fair market price' test be monitored and enforced and who would be responsible for doing so?*
- (b) *Is the remedy reasonable? Should certain kinds of arrangement still be permitted and if so which? Should, for example, those with a value of less than a certain amount, be deemed 'de minimis'? If so, what should this figure be?*
- (c) *Is the remedy comprehensive? Should it apply to other healthcare service providers such as laboratories or firms supplying diagnostic services such as imaging, for example? Should PMIs be permitted to operate incentive schemes which reward consultants who recommend cheaper treatments or less expensive hospitals?*
- (d) *Are there regulatory regimes in other jurisdictions that the CC could learn from in the context of remedy specification and implementation? Would, for example, the Stark Law in the USA, be a useful model as regards restrictions on the*

¹⁹ These schemes do not include those where the reduction in barriers to entry created is at least as beneficial to competition as any distortion is harmful.

commercial relationships between healthcare facilities and clinicians and their introduction?

- (e) *What would be the cost of implementing this remedy, particularly in terms of unwinding existing equity sharing arrangements? Would it be necessary or desirable to 'grandfather' existing arrangements?*
- (f) *Particularly in the context of market entry and expansion, are any relevant customer benefits likely to arise from equity participation by consultants in hospitals that would not otherwise be available?*

Lack of sufficient publicly available performance information on consultants

64. We have provisionally concluded that lack of publicly available information on consultants is a feature of the private healthcare market which gives rise to an AEC. This feature has two aspects: consultant performance and consultant fees. We set out our proposed remedy for each in turn below.

Consultant quality

65. We were satisfied that information concerning consultants' professional qualifications and areas of expertise was accessible to consumers in the UK via websites such as Dr Foster, hospitals' and consultants' own websites. However, with the exception of cardiothoracic surgeons, information on the clinical performance of individual consultants was not available.
66. In December 2012, NHS England announced plans to collect and disseminate performance data for individual consultants in ten medical specialties. It was intended that this information would be published in the summer of 2013 and data on the performance of cardiothoracic surgeons is now available publicly.²⁰ We found there were no plans for the NHS in Scotland, Wales or Northern Ireland to publish similar data.
67. We considered that the provision of this information to patients would be sufficient to provide a solution in England to this aspect of the AEC that we had provisionally identified. However, we did not consider that the publication of this data would comprehensively address the AEC since it would not provide relevant information for patients across the whole of the UK.
68. We are therefore considering a recommendation to the health departments of Scotland, Wales and Northern Ireland that they collect and publish consultant performance indicators arising from their NHS practice equivalent to that published in England.

Remedy 5—a recommendation to the health departments of the nations

- *How the remedy would work*

69. We would make 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

²⁰ [Everyone Counts: Planning for Patients 2013–2014](#).

range of medical specialties to that included in the NHS England scheme. Data would, as in England, be standardized so as to permit a genuine like-for-like comparison between consultants in the same specialty but working in different parts of the UK.

- *Issues for comment 5*

70. We invite responses to the following questions:

- (a) Is the proposed remedy practicable in all of the nations? Where a consultant practises partly in one nation and partly in another should performance data published in one nation be confined to that relating to performance in that nation?*
- (b) Is the proposed list of ten specialties²¹ for which performance data will be available on an individual clinician basis appropriate?*
- (c) Are the indicators that are currently published for consultants in each of the ten specialties, the way they are presented and the manner of their distribution appropriate? Are they (or some combination thereof) appropriate for other areas of specialty? If not, which indicators would it be appropriate to adopt for each specialty and how should they be presented and distributed?*
- (d) Does the remedy risk giving rise to unintended consequences? Even with standardized mortality rates, might consultant incentives to treat more seriously ill patients be affected?*
- (e) With what frequency should performance indicators be updated?*

Consultant fees

Remedy 6—An information remedy

71. We were also concerned that information relating to consultants' charges was not uniformly made available to patients prior to consultations and/or treatments with the result that patients may face unexpected shortfalls in their PMI reimbursement. Some consultant bodies, for example AAGBI, produce a code of practice on charging and fee notification to patients. However, we did not find this practice to be widespread.
72. We therefore considered a remedy that would require consultants to provide patients with price information prior to the commencement of treatment.
 - *How the remedy would work*
73. We would require all consultants practising in the private healthcare sector to publish their initial consultation fees on their websites and we would require each private hospital where they have practising rights to publish these fees on their websites. We would, further, require consultants to provide a list of proposed charges to patients in writing, in advance of any treatment.
 - *Issues for comment 6*
74. We invite responses to the following questions:

²¹ See [Everyone Counts: Planning for Patients 2013–2014](#).

- (a) *Is the remedy practicable? Do consultants' outpatient fees vary significantly between different patients such as to render an average fee or a range of fees unhelpful?*
- (b) *Is it possible for consultants to estimate fees before undertaking a procedure since unforeseen complications may arise? Would there need to be a means of adjusting fees in response to complications? Are there particular medical specialties where consultants would face particular problems in providing such an estimate in advance? How else might patients be informed of the likely costs of their treatment?*
- (c) *Is it reasonable to require all consultants practising in the private sector to disclose their outpatient consultation fees? Should only those earning above a certain level do so?*
- (d) *How should the remedy be specified? How far in advance of treatment should a consultant be required to provide a patient with an estimate of the proposed fees for treatment? Is it practical, in all cases, to inform patients of costs in advance of treatment? Should any other information or advice be included with the estimate? For example, should the consultant notify the patient of his or her PMI fee maximum for the procedure concerned, or advise the patient to check this him or herself?*
- (e) *What provisions would need to be made for the oversight and enforcement of this remedy and which body(s) should be responsible?*

Lack of sufficient publicly available information on private hospital performance

Remedy 7—An information remedy

- 75. Much more information is currently available to consumers on the quality of services provided by NHS hospitals than is available for private hospitals.
- 76. Information on the performance of NHS hospitals in England, and on the performance of private hospitals in respect of work they undertake on behalf of NHS England, includes collection of data for the assembly of hospital episode statistics (HES)²² comprising detailed information on procedures and patients as well as patient reported outcome measures (PROMS) which provide qualitative information on patient care in the context of four commonly performed procedures.²³
- 77. In late April 2013 the Private Hospital Information Network (PHIN)²⁴ launched a website providing information on the performance of its member hospital operators across a number of indicators including the equivalent of HES. We have been told that PHIN intends to widen the scope and coverage of the information that it collects and publishes. At this stage it is not clear to us that the data to be published by PHIN will necessarily be equivalent to that available on the performance of NHS hospitals in England.

²² www.hscic.gov.uk/hes.

²³ These are hip and knee replacement, groin hernia repair surgery and the removal of varicose veins.

²⁴ The initiative was previously known as the Hellenic project.

- *How the remedy would work*

78. 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.

- *Issues for comment 7*

79. We invite responses to the following questions:

(a) *Is the remedy practicable? Are all private hospitals in the UK capable of collecting the equivalent of HES data? If they are not currently capable of doing so, what would be a reasonable timescale for the implementation of this remedy?*

(b) *Similarly, are all private hospitals in the UK capable of collecting PROMs data for the same procedures that it is collected for NHS England? If they are not currently capable of doing so, what would be a reasonable timescale for the implementation of this remedy?*

(c) *Besides HES and PROMs equivalent data, what other data should be collected by private hospitals and to whom should it be made available? Would it be appropriate for the CC to specify the coding, for example ICD10, to be used in data collection and classification?*

(d) *What measures could or should the CC adopt in order to ensure that PHIN or its equivalent retains sufficient funding to continue its activities after the completion of the CC investigation?*

(e) *What cost and other factors should the CC take into account in considering the reasonableness and proportionality of this remedy or the timing of its implementation?*

Remedies we are minded not to consider further

80. We set out below a remedy option which we have considered but currently do not intend to pursue and explain our reasoning. Although we are minded not to consider it further we will do so if the parties to the investigation or other interested parties provide us with evidence or reasoning as to why we should take this remedy into account.

Insufficiency of competitive constraints

Remedy 8—A price control

81. A price control would set the maximum prices that could be charged at hospitals which we consider have market power.

82. We thought that while this remedy would be effective for both insured and self-pay sectors it would not address the root cause of the problem. The CC has a clear preference for remedies which address the cause of a competition problem and not its symptoms.²⁵

²⁵ [Guidelines for market investigations](#), CC3 Revised, paragraph 330.

83. In addition, a price control would be complex to design and update, would require the provision of some form of adjudication in the event of disputes and would be likely to have unintended consequences, such as deterring new entry.
84. Despite these drawbacks, we did consider whether a price control would be an appropriate remedy in the case of Single and Duopoly areas where, despite the rise in local pricing that might arise from our remedies 2 or 3, new entry or expansion was unlikely, for example because of the insufficient number of prospective customers (PMI, self-pay and NHS) in the catchment area. On balance we decided that it would not be an appropriate remedy. However, we invite views on this, including to the contrary.

Relevant customer benefits

85. In deciding the question of remedies, the CC may in particular have regard to the effect of any action on any relevant customer benefits (RCBs) of the feature or features of the market concerned.²⁶
86. 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 (whether or not the market to which the feature or features concerned relate); or
 - (b) greater innovation in relation to such goods and services.
87. The Act²⁷ provides that a benefit is only an RCB if the CC believes that:
- (a) the benefit has accrued as a result (whether wholly or partly) of the features concerned or may be expected to accrue within a reasonable period of time as a result (whether wholly or partly) of that feature or those features; and
 - (b) the benefit was or is unlikely to accrue without the feature or features concerned.
88. In considering potential RCBs, the CC will therefore need to ascertain that the market feature or features with which it has been concerned results, or is likely to result, in lower prices, higher quality, wider choice or greater innovation, and that such benefits are unlikely to arise in the absence of the market feature or features concerned. RCBs may include benefits to customers in the market in which the CC has found an AEC and to customers in other markets within the UK.
89. If the CC is satisfied that there are RCBs deriving from a market feature that has resulted in an AEC, the CC will consider whether to modify the remedy that it might otherwise have imposed or recommended. When deciding whether to modify a remedy, the CC will consider a number of factors including the size and nature of the expected benefit and how long the benefit is to be sustained. The CC will also consider the different impacts of the features on different customers.
90. It is possible that the benefits are of such significance compared with the effects of the market feature(s) on competition that the CC will decide that no remedy is called for. This might occur if no remedies can be identified that are able to preserve the RCBs while remedying or mitigating the AEC and/or the customer detriment.

²⁶ [Guidelines for market investigations](#), CC3 Revised, paragraphs 355–369.

²⁷ Section 134(7).

91. Alternatively, the CC, as a result of identifying RCBs, may choose a different remedy, for example a behavioural rather than a structural remedy. In this case, the CC will have to weigh the disadvantage of a less comprehensive solution to the competition problem against the preservation of the benefits that result from the feature concerned.²⁸

Next steps

92. The parties to this investigation and any other interested persons are requested to provide any views in writing, including any suggestions for additional or alternative remedies that they wish the CC to consider, by 20 September 2013 either by email to privatehealthcare@cc.gsi.gov.uk or in writing to:

²⁸ [Guidelines for market investigations](#), CC3 Revised, paragraphs 360–369.

Divestment options

Introduction

1. We have provisionally found that high barriers to entry and weak competitive constraints in many local markets in the UK, including central London give rise to an AEC in the provision of privately funded healthcare by hospitals. We have set out in our Notice of possible remedies those remedies that we are minded to pursue, including the divestment of one or more hospitals and other assets in some of those areas where we have provisionally found an AEC.
2. We now set out:
 - (a) the approach we have adopted in identifying local areas where we consider divestment would be an effective remedy; and
 - (b) the approach that we have adopted in specifying the divestiture package in each local area, including in central London.

Our approach to identifying local areas where divestment would be an effective remedy

Areas where divestment would not address the AEC

3. We first reasoned that divestiture would not address the AEC in areas which we considered to be Single or Duopoly areas, as defined in our Notice of possible remedies¹ since it would transfer local market power from one hospital operator to another, rather than remove it.
4. Divesting a Single hospital would not remove market power. Neither would divestment in local areas where there are only two hospitals owned by different operators: the sale of one of them would not increase rivalry since the number of rivals will remain the same as before. In both cases, the market power would simply transfer from one operator to another.
5. In contrast, in local areas where there are two or more hospitals owned by a single operator, ie 'clusters', we considered that divestment could be an effective remedy to the AEC.
6. 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.
7. We set out below the approach we have adopted in identifying local areas outside central London where we consider divestment would be an effective remedy, including distinguishing Single and Duopoly areas from clusters.

¹ See our Remedies Notice, paragraphs 23 & 24.

Local areas outside of central London

Areas where divestment would be an effective remedy

8. Our detailed local competitive assessments identified 101 hospitals outside central London which we provisionally found faced insufficient local competitive constraints and are therefore able to exercise a degree of unilateral market power.² However, as stated in paragraphs 3 to 5, above, we did not consider that divestment was likely to be an effective remedy to the AEC in all these areas.
9. In this section, we set out our approach to identifying in which of these local areas a divestment remedy is likely to be effective in increasing competitive constraints. Our approach employed LOCI analysis, price concentration analysis (PCA) and a detailed assessment of local areas which these led us to investigate further.

LOCI

10. We first used the LOCI analysis to help us identify in a systematic way clusters of hospitals owned wholly or predominantly by one operator and where a divestiture remedy would increase the overall level of competitive constraints.
11. The LOCI analysis provided an indicative quantitative estimate of the effect of co-ownership on concentration in each local area. For each hospital we have calculated both an individual and a network LOCI based on data from insured patients, with the former identifying the market share of the individual hospital in the local area and the latter identifying the market share of the hospital group in the local area.³ The difference between these two figures represents the ‘network effect’ or the increase in the hospital’s market share that results from the co-ownership of other facilities in the local area. Where the network effect is small, a hospital is closer to the Single/ Duopoly case and the divestment of a co-owned hospital in the local area is less likely to be effective in increasing competitive constraints.
12. Table 1 sets out the number of hospitals of concern identified by our local assessments for each hospital group, which we have categorized by the size of the network effect.

TABLE 1 Hospitals of concern (excluding central London)

Network effect	Number of hospitals of concern					Total
	BMI	Spire	Nuffield	Ramsay	Others	
0+	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	101
0.05+	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	68
0.1+	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	47
0.15+	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	32
0.2+	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	20
0.25+	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	16
0.3+	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	12
0.4+	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]	4

Source: CC analysis.

² These figures include two NHS-operated PPUs in the South-East of England.

³ See Appendix 6.4 for a full description of the difference between individual and network LOCI.

PCA

13. While the existence of any network effect indicates that co-ownership is increasing concentration, we next considered the extent to which a decline in local concentration might be expected to lead to an improvement in competitive outcomes for consumers, such as lower prices and higher quality. We considered that this would help us to determine whether divestiture would be appropriate since in areas where the network effect was present but weak a divestment capable of reducing prices materially might be disproportionate.
14. We considered that our PCA provided an insight into the likely impact of divestments on prices. The PCA identified and quantified a general relationship between concentration at the local level and self-pay price outcomes. It indicated that reductions of around 20 percentage-points in a hospital's weighted-average market share are expected to lead to, on average, a 2 to 6 per cent decline in the average price charged to self-pay patients, with our preferred estimates lying between 3 and 4 per cent.⁴
15. We recognize that, while we have provisionally found that weak competitive constraints arising from local concentration, combined with barriers to entry, increases insured prices,⁵ the relationship identified in the PCA does not provide direct evidence regarding the size of the effect of concentration on insured prices, since it relates to self-pay patients only. However, we believe that the PCA is likely to be illustrative in terms of the size of the effect and that an average price reduction in the region of 3 per cent for self-pay patients is a reasonable starting point for our analysis of in which local areas divestment would be an effective remedy, since we consider that 3 per cent, corresponding to a 20 percentage points decline in market share, represents a material reduction in prices.⁶

Hospitals of concern

Detailed local assessment

16. On the basis of this analysis and reasoning we focused initially on those hospitals of concern with a network effect of 0.2 or more, of which there are 20 (see Table 1). These 20 hospitals were located in 11 separate local areas, with some areas containing more than one hospital of concern. We considered that divestitures would be an effective remedy in these local areas. Within these areas, we have considered a range of factors⁷ in coming to an initial view on whether a divestiture would in fact be appropriate in the local area.
17. Table 2 lists the hospitals that have been identified based on having a network effect of 0.2 or more.

TABLE 2 Hospitals identified in areas of concern (network effect)

[✕]

Source: CC analysis.

⁴ Appendix 6.9.

⁵ See provisional findings, Section 6.

⁶ While the PCA is illustrative of the local price effects that are likely to result from reductions in concentration, the existence of national tariffs prices for insured patients means that a decline in concentration in one local market is likely to mean a decline in the overall national tariff price agreed between the PMIs and the PHP affected.

⁷ See paragraph 19.

18. In addition to using LOCI analysis and PCA to identify local markets in which divestments would be effective in increasing competitive constraints we have also drawn from our local assessments,⁸ which identified areas in which clusters of co-owned hospitals meant that insurers (and self-pay patients) had limited choice of PHP. In most cases, the areas identified by our local assessments were the same as those identified by the LOCI analysis and PCA. In some cases, however, this approach identified clusters of hospitals in which the network effect associated with each hospital in the area fell slightly below the 0.2 network effect but where, nevertheless, there appeared to be the potential for divestments to have a significant impact on competitive dynamics. Table 3 sets out the additional hospitals/areas identified for potential divestments on the basis of our detailed local assessments.

TABLE 3 Hospitals identified in areas of concern (local assessments)

[X]

Source: CC analysis.

Specifying the divestiture package

19. Having identified local areas in which divestitures would be effective in addressing the AEC, we reasoned that five main factors could be relevant to a decision as to the appropriateness of a divestment and the specification of the divestiture package:
- (a) the range of medical services (specialties) offered by the hospitals, including the availability and type of ICU;
 - (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.
20. We propose to use these factors to identify areas in which divestiture of one or more hospitals and other assets would be effective in remedying the AEC arising from weak competitive constraints, combined with high barriers to entry.

⁸ Appendix 6.7.