

## PRIVATE HEALTHCARE MARKET INVESTIGATION

### Statement of issues

22 June 2012

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.<sup>1</sup>
2. The terms of reference define privately-funded healthcare services as services provided to patients via private facilities/clinics, including private patient units (PPUs),<sup>2</sup> through the services of consultants, medical and clinical professionals who work within such facilities.
3. The privately-funded healthcare sector involves a variety of suppliers of services and also the private medical insurers<sup>3</sup> which fund many of the services provided to patients. The suppliers of the services include hospital operators,<sup>4</sup> consultants, GPs,<sup>5</sup> other medical and clinical professionals and the NHS.<sup>6,7</sup> Our terms of reference call on us to investigate the various facets of the privately-funded healthcare sector. This will include investigating how competition in the privately-funded healthcare sector is affected by the conduct of private medical insurers although we do not anticipate investigating how competition functions in the private medical insurance market(s).<sup>8</sup> Our investigation covers the whole of the UK and we recognize that we will need to consider any differences between the nations of the UK. We note also that healthcare services funded by the NHS whether carried out in NHS facilities or in privately-operated hospitals are outside the terms of reference.
4. This issues statement is based on our initial consideration of an appropriate framework for the investigation taking into account the OFT's decision document and the evidence we have reviewed to date. We are publishing this statement now to assist those submitting evidence to focus on the issues we envisage being relevant to this investigation. The points raised in this document are intended as topics for investigation and do not represent any views or findings of the CC. If parties consider that there are additional issues which we should consider, they are invited to identify them and to explain why these are relevant to our investigation.
5. To submit evidence, please email [Private-Healthcare@cc.gsi.gov.uk](mailto:Private-Healthcare@cc.gsi.gov.uk) or write to:

<sup>1</sup> *Private Healthcare Market Study, OFT1412, April 2012.*

<sup>2</sup> PPU's include individual beds, wards or separate wings/units within publicly-funded facilities provided to privately-funded patients.

<sup>3</sup> For the purposes of this statement, 'insurer' is used to refer to private medical insurers.

<sup>4</sup> For the purposes of this statement, 'hospital operator' refers to a person who operates private facilities and clinics including PPUs operated by the National Health Services within the UK. The terms 'hospital' and 'facilities' are similarly used to include private facilities and clinics, whether inpatient or outpatient.

<sup>5</sup> This includes NHS and private practice general practitioners.

<sup>6</sup> In this statement 'the NHS' refers to the publicly-funded healthcare services of each nation within the UK. See further paragraph 14 on the interaction of the NHS.

<sup>7</sup> We also note the role of pharmaceutical companies and equipment suppliers. However, based on current information, we are not proposing to investigate this aspect of privately-funded healthcare.

<sup>8</sup> The OFT did not refer the private medical insurance market(s) for investigation.

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by **20 July 2012**.

## **Our approach**

6. We are required to decide whether any feature or combination of features of each relevant market prevents, restricts or distorts competition in connection with the supply or acquisition of goods or services in the UK or a part of the UK. If that proves to be the case, under the Act this constitutes an adverse effect on competition (AEC).<sup>9</sup>
7. We will define the economic market(s) and consider whether there is any feature, or combination of features, in the relevant market(s) that results in an AEC. In order to determine whether this is the case we initially develop a set of 'theories of harm'. These should not be mistaken for a finding of harm; rather they hypothesize the potential market failures that could be preventing, restricting or distorting competition and which we wish to explore as the inquiry progresses. In this way, the theories of harm are a tool that enables us to identify any features or combination of features that may result in an AEC. The role of the theories of harm is discussed in more detail in paragraph 19.

## **Characteristics**

8. Certain underlying characteristics of the way that privately-funded healthcare services operate appear to be particularly relevant when assessing competition in the sector. Identification of these characteristics has informed our formulation of the theories of harm and we set out below the key characteristics we have identified to date. We welcome observations on both the identification of these as key characteristics and whether there are others we should consider.
9. Privately-funded healthcare services are highly varied. They are provided from a variety of facilities, hospitals, clinics and PPUs and through consultants and other medical and clinical specialists working within these facilities. Treatments depend on clinical judgements and need to take account of patient (consumer) circumstances. Not all hospitals or consultants offer the same range of treatments or the same services or approaches for each treatment. We note that the five largest hospital operators account for approximately 70 per cent of privately-funded healthcare revenues in the UK.<sup>10</sup>
10. Almost 80 per cent of UK patients are funded by insurance with self-pay UK patients accounting for approximately 20 per cent of privately-funded healthcare services in the UK, the remainder being overseas patients.<sup>11</sup> For insured patients, payments for

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<sup>9</sup> See section 134(1). Features may be structural and also include any conduct of the person who supplies or acquires the services in the reference market or conduct relating to the reference market of customers of any person who supplies or acquires the services.

<sup>10</sup> Laing & Buisson Healthcare Market Review 2011-12.

<sup>11</sup> In 2011, the breakdown of privately-funded healthcare revenues was: 77.9 per cent insured patients, 18.5 per cent self-pay patients and 3.6 per cent overseas patients, according to Laing & Buisson Healthcare Market Review 2011-12.

insurance are made separately from decisions on the need to seek healthcare. We will want to explore the fact that it is not always the patient who pays for insurance, since in many cases, for example under corporate group policies, the patient's employer selects the insurance and funds the premium wholly or partially.

11. We will wish to understand the significance of the fact that most treatments are paid for by insurance, meaning that the identity of the consumer and funder differ. In addition, the price paid by the insurer when one of its policyholders is treated will depend on the rates it has negotiated with the respective healthcare provider. Typically, where a healthcare provider owns a chain of hospitals, it will negotiate a single national price for a given treatment with each insurer.
12. Decisions by patients on the need to seek specialist healthcare and from whom to seek such healthcare are usually made with the involvement of the GP,<sup>12</sup> in the case of the former, and the consultant or other specialist, in the case of the latter. This applies to both insured and self-pay patients. Some comparable information on hospitals and consultants is available to patients. We will wish to understand further how this information is used and how choices are made by the patient in practice, including the effects of GP and consultant advice on the selection of healthcare provider.
13. We will wish to understand the significance of the roles played by insurers as well as the incentives they face to influence a patient's choice of healthcare service. The four largest private medical insurers account for approximately 87 per cent of premium revenue.<sup>13</sup> Insurers have some influence on the selection and delivery of services through factors such as:
  - (a) approving hospitals, consultants and other healthcare professionals under their policies;
  - (b) restrictions in insurance products that direct patients towards/away from certain facilities or limit access to particular services or consultants and other medical and clinical professionals; and
  - (c) the setting of financial caps for individual treatments and/or involvement in the selection of treatment.
14. The privately-funded healthcare sector is a relatively small part of the wider UK healthcare sector, most of which is funded via each nation's respective public healthcare systems. We are conscious that the NHS interacts in a number of ways with the privately-funded healthcare sector. The NHS is a:
  - (a) customer of the hospital operators when NHS patients are treated in private hospitals;
  - (b) supplier of privately-funded healthcare services through PPUs;
  - (c) partner with hospital operators, for example through PPU partnerships or through the development/provision of specialist treatments, equipment or research;
  - (d) supplier of national health services to patients free at point of delivery, representing an alternative to privately-funded healthcare;

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<sup>12</sup> We are aware that some other health professionals can also refer patients for treatment but we intend to focus on referrals by GPs.

<sup>13</sup> Laing & Buisson Healthcare Market Review 2011-12.

- (e) main employer (and for many also the trainer) of most consultants that provide privately-funded healthcare services;
  - (f) main funder (and for many also the trainer) of most GPs; and
  - (g) source of all training for almost all other medical and clinical professionals.
15. We will wish to understand the relevance of these interactions and the extent to which they affect competition in the privately-funded healthcare sector.

## Market definition

16. As set out in *Market Investigation References: Competition Commission Guidelines, CC3* (paragraph 1.21), we will normally approach a market investigation through consideration of two related issues: the identification of the relevant market or markets for the goods or services concerned; and an assessment of competition in the market and whether any features of the market create an AEC. We consider the definition of the relevant market(s) and the examination of competition within those market(s) to be overlapping parts of the same analysis. For example, the analysis of competition in a local area (see theory of harm 1 below) is closely associated with the analysis to determine the scope of the relevant geographic market. However, our examination of competition is not constrained by market definition; we will take into account, as necessary, constraints outside the relevant market, segmentation within the relevant market, or other ways in which some constraints are more important than others.
17. When considering the relevant product market(s) in the context of privately-funded healthcare services there are several issues we will need to take into account. These include:
- (a) Treatments are characterized by varying degrees of complexity and are highly differentiated products:
    - (i) not all hospitals/consultants offer the same range of treatments or the same services/approaches for any type of treatment (eg outpatient versus inpatient care, surgery versus physiotherapy); and
    - (ii) treatments supplied by different hospitals/consultants may also differ in terms of the way in which treatment is provided.
  - (b) The ability of patients to switch is likely to be very limited (if any) as patients cannot typically replace one treatment for another. However, in certain cases, there could be some substitutability between alternative approaches for a particular treatment.
  - (c) Suppliers may be able to change the services they supply if they supply a range of different products/services and may be able quickly to change how they operate. The extent of substitution between treatments may vary depending on whether the services of a consultant or of a hospital for a particular treatment are being considered. In particular, supply-side substitution by consultants is likely to be more limited than supply-side substitution by hospitals. In addition, the competitive influence of different hospitals/consultants may be asymmetric (eg a general hospital may constrain a diagnostic centre but the reverse may not be the case).
  - (d) In the absence of demand-side and supply-side substitution, treatments (or specialities) that should be defined as separate markets may be aggregated into

clusters of treatments. This may be appropriate when a group of suppliers each supply a range of treatments and the competitive conditions are the same for each treatment. However, as discussed in paragraph 18(b) below, this could lead to distortions when considering the scope of the relevant geographic market(s).

- (e) The identity of competitors in each of the relevant product market(s) may vary according to the specific treatments (or specialities) within the relevant product market and offered by each provider. We will also need to understand the extent to which PPUs represent a competitive constraint on hospital operators or whether the NHS represents a material competitive constraint on privately-funded healthcare services.

18. When considering the relevant geographic market(s) there are also several issues we will need to take into account. These include:

- (a) Both local and non-local factors are likely to be relevant for geographic market definition:
  - (i) local aspects may arise because patients may prefer not to travel too far to hospitals or because there may be limits on patients' ability to travel (eg limited geographic coverage by the insurer or GPs referring primarily to local consultants); and
  - (ii) non-local aspects may arise as negotiations between insurers and hospital operators take place at a national level. We will need to consider whether and how the size/extent of a hospital operator's network and the degree of a hospital operator's local market power affect the scope of the relevant geographic market(s) when negotiations between insurers and hospital operators are considered.
- (b) Patients may be willing to travel different distances depending on the type of treatment (eg patients may be willing to travel longer distances for treatments for more serious conditions). Whether particular treatments are in the same product market may therefore impact on the relevant geographic market at the local level.<sup>14</sup>
- (c) Hospitals differ by location. In addition, competition between hospitals may take place between hospital chains (networks) as well as between individual hospitals.

## Theories of harm

19. We have identified seven theories of harm which we have set out below. Our investigation is at an early stage, and the purpose of identifying these hypotheses or theories of harm is to present some early thinking on how the issues stand independently and might fit together, so as to help frame our investigation. Their identification does not mean that we have reached any conclusions on whether these hypotheses apply, nor have we yet reached conclusions on any of the issues set out in this statement. The identification of these theories of harm does not preclude an AEC being identified on another basis following further work by us or the receipt of additional evidence.

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<sup>14</sup> For example, if patients have different willingness to travel for different types of treatment, identifying a very broad product market such as 'privately-funded acute general hospital care' (based on supply-side substitution considerations or clustering of services due to a common set of competitors), may disguise the fact that competition takes place over a smaller geographic area for certain treatments.

20. The theories of harm we have identified are:
- (a) theory of harm 1: market power of hospital operators in certain local areas;
  - (b) theory of harm 2: market power of individual consultants and/or consultant groups in certain local areas;
  - (c) theory of harm 3: market power of hospital operators during national negotiations with insurers;
  - (d) theory of harm 4: buyer power of insurers in respect of individual consultants;
  - (e) theory of harm 5: barriers to entry at different levels;
  - (f) theory of harm 6: limited information availability; and
  - (g) theory of harm 7: vertical effects.
21. These theories of harm are each discussed below. Different theories of harm are related to each other. For example, theory of harm 1 requires consideration of barriers to entry that are identified within theory of harm 5. Further, an AEC finding may be found to have resulted from a feature or a combination of features. The identification of several different theories of harm will not prevent a finding of an AEC based on a combination of features that were identified initially under separate theories of harm.

***Theory of harm 1: market power of hospital operators in certain local areas***

22. The first theory of harm is that a hospital operator may have market power with respect to patients in a particular geographic area.
23. Several factors may result in a hospital operator holding local market power in a particular area. These include:
- (a) a limited number of rival hospitals nearby;
  - (b) a limited number of rival hospitals nearby that offer or specialize in a particular treatment; or
  - (c) a limited number of rival hospitals nearby with significant spare capacity.
24. Constraints provided by rival hospitals in a local area may differ depending on the treatment being sought. As such it is possible that hospitals in certain locations may have market power in respect of some treatments but not for others (see paragraph 17(e)).

***Effects of hospital operator local market power***

25. In general we would expect limited competition in particular local areas to be likely to lead to higher prices for treatment and/or a lower quality of service.<sup>15</sup>

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<sup>15</sup> In this statement, in referring to 'quality' we include all attributes of the product/service which may provide value to the consumer, including but not limited to: clinical outcomes, speed and convenience of treatment, comfort of accommodation, standards of customer service etc.

26. In relation to prices, for insured patients the price is paid by the insurer and is normally the result of negotiation between the hospital operator and the insurer. We will consider whether in these negotiations the hospital operator has market power and whether the insurer has significant countervailing buyer power. The effects on price will depend on the results of these negotiations; these are discussed under theory of harm 3.

***Theory of harm 2: market power of individual consultants and/or consultant groups in certain local areas***

27. Theory of harm 2 hypothesizes that consultants or consultant groups in certain local areas have market power over their patients. We also note that consultants usually (at least in the case of insured patients) provide a separate bill specifying their charges.
28. Consultant market power may be caused by several factors, some specific to the location in which the consultant works and others reflecting the way in which privately-funded healthcare services are purchased. These factors include:
- (a) a limited number of consultants in a particular local area for specific treatments/specialities;
  - (b) the way that referrals are made and consultants selected. If patients and their GPs do not shop around before selecting the most appropriate consultant, historic referral patterns could become entrenched and incumbent consultants may face limited competitive pressure. We may look separately at anaesthetists since the process for choosing anaesthetists for a patient appears to differ from that for other consultants; and
  - (c) the joint setting of prices (for anaesthetists).<sup>16</sup> We are not aware of the existence of such arrangements in respect of other consultant groups.

*Effects of consultant local market power*

29. The effects of consultants having local market power may differ depending on the type of patient being considered:
- (a) if insured patients' policies include a limit on consultants' fees insured patients may have to make additional payments. If a consultant's fees are covered by the insurer, high fees are likely to lead to high insurance premiums; and
  - (b) self-pay patients may also face high charges; and
  - (c) both self-pay and insured patients may suffer from a reduced quality of service.

***Theory of harm 3: market power of hospital operators during national negotiations with insurers***

30. Theory of harm 3 concerns negotiations over the price that an insurer pays when its insured patients are treated in a hospital. We understand that these negotiations typically result in a national price(s) for a given treatment which applies to all or

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<sup>16</sup> The OFT report discusses the fact that there have been a number of complaints about anaesthetists setting prices collectively.

almost all the hospitals owned by that particular hospital operator. This theory of harm hypothesizes that, in some bilateral negotiations, a hospital operator may have market power which is not offset by the buyer power of the insurer. It is linked to the separation between the party paying for the treatment and those who decide on the need for treatment.

31. If a hospital operator has market power when negotiating a national contract with an insurer this is likely to derive from the former's local market power and/or the scale of its network. We will need to consider whether:
  - (a) the hospital operator owns at least some hospitals which confer upon it local market power (because of the location of the hospital compared with rivals' hospitals, or the size, or the specialities offered) so that the insurer has little or no choice but to contract with the hospital operator and recognize such hospitals if it is to offer an insurance policy to consumers living or working in that area; and
  - (b) if the above applies, the insurer has little or no choice but to recognize all or most of the hospital operator's hospitals (ie not only those hospitals with local market power in paragraph 33(a)) if it is to provide national coverage.
32. This theory of harm depends on the respective bargaining power of the insurer and the hospital operator and assumes that the insurer is in a weak position. However, we note that insurers may have some leverage in these negotiations through potentially two mechanisms, both related to the insurer asserting more control over where the patient is treated:
  - (a) first, the insurer could use the threat of not including a given hospital or only certain treatments within a particular hospital in its network(s) (so called 'delisting') to extract a better national price from a hospital operator; and
  - (b) secondly, the insurer may be able to develop mechanisms to influence the patient's choice of hospital or 'steer' patients away from one hospital operator/hospital to another.

#### *Effects of some hospital operators' market power in national negotiations*

33. The effects of some hospital operators having market power when negotiating with insurers may be:
  - (a) insurers may have to pay a higher price when an insured patient is treated at a hospital owned by hospital operators with market power. This may in turn result in higher insurance premiums; and
  - (b) network recognition may not reflect the competitive strengths of individual hospitals in local areas (on the basis of price and quality).<sup>17</sup>
34. We note that we may need to consider a separate theory of harm, whereby the insurers have buyer power over hospital operators, such that insurers may exert too much pressure on the price paid to the hospital operator. As a result hospital operators may reduce investment in facilities and equipment. If the market for private medical insurance is not competitive, such lower prices paid to hospital operators may not be passed on fully to purchasers of insurance through lower premiums.

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<sup>17</sup> See paragraph 46 (theory of harm 5) for further discussion on why national negotiations between insurers and hospital operators may mean that network recognition is not based on the relative merits of hospitals in a particular area.

#### ***Theory of harm 4: buyer power of insurers in respect of individual consultants***

35. We understand that it is common for insurers to stipulate in their policies that there is a maximum reimbursement rate that they will pay consultants for a given treatment. Consultants may charge more than this amount for their services, in which case the insured patient is obliged to pay the excess. This may be subject to the terms of the agreement between the consultant and the insurer. We understand that some insurers stipulate that in order for certain consultants to be recognized to treat their policyholders, the consultant must agree not to charge more than the amount specified by the insurer.
36. Caps on the reimbursement of fees may be used by insurers to limit overcharging by consultants (see theory of harm 2). However, this theory of harm hypothesizes that insurers may possess buyer power in relation to consultants which results in consultant fees being too low.

#### ***Effects of insurer buyer power over consultants***

37. If insurers are suppressing consultant fees to a level below those which would prevail in a competitive market, this could lead to a reduction in the quality of service provided by consultants to patients and affect the incentives to innovate. In addition, there may be distortions to competition between consultants when caps on the reimbursement of fees are applied to some consultants (eg newer or junior consultants) and not to others (eg more experienced ones). In the longer term, this may result in a shortage of consultants willing to practice and in a reduction in the potential output of the sector.

#### **Theory of harm 5: barriers to entry**

38. This theory of harm hypothesizes that there are barriers to entry which reduce competition, either directly or by providing the necessary conditions for the other theories of harm to have effect. We have identified four classes of potential barriers to entry:
  - (a) barriers to entry into privately-funded healthcare provision resulting from national bargaining between insurers and hospital operators;
  - (b) barriers to entry into privately-funded healthcare provision resulting from the relationships between hospital operators and consultants or GPs;
  - (c) other barriers to entry into privately-funded healthcare provision; and
  - (d) barriers to entry into the provision of consultant services in private practice.

#### ***5(a) barriers to entry into privately-funded healthcare resulting from national bargaining between insurers and hospital operators***

39. This theory of harm hypothesizes that national bargaining between insurers and hospital operators creates barriers to new local entrants. In particular, it may result in contractual terms that prevent or disincentivize insurers from recognizing new entrants.
40. This theory of harm relies on hospital operators having market power in national negotiations as discussed in theory of harm 3. It hypothesizes that the national negotiations between insurers and large national (or regional) hospital operators over

price and hospital recognition could make it difficult for new hospital operators to gain insurer recognition for new hospitals.

41. If the large national (or regional) hospital operators have market power in some local areas, in order to offer nationwide coverage, insurers may have to contract with most of the large national (or regional) hospital operators, at least in relation to those hospitals located in areas where each hospital operator has market power.
42. Large national (or regional) hospital operators may want to ensure that most or all of their hospitals are recognized by insurers to cover high fixed costs and reduce the risk of stranded assets. Such hospital operators may seek to use the market power derived in local areas to seek to achieve recognition of their hospitals in competitive areas.
43. This national bargaining pattern may lead to a hospital operator placing pressure on insurers to continue to recognize all the hospital operator's hospitals and not to recognize hospitals of new entrants.

***5(b) barriers to entry into privately-funded healthcare services resulting from the relationships between hospital operators, consultants or GPs***

44. Such barriers to entry may arise due to:
  - (a) the need for a new entrant to obtain commitment from consultants to work in the new hospital in order to get insurer network recognition and, more generally, sufficient 'demand' for its services and, on the other hand, the need to guarantee enough demand by insured and self-pay patients to attract consultants away from incumbents' facilities;
  - (b) incentives provided by hospital operators to consultants; and
  - (c) incentives provided by hospital operators or consultants to GPs.

*Relationship between hospital operators and consultants (paragraphs 44(a) and (b))*

45. Consultants may be considered as a key asset for hospital operators given that patients are usually referred by their GP to a consultant rather than to a hospital. Consultants may play a major role in bringing patients into a hospital and generating revenue for the hospital operator. Where consultants tend to focus their work at one main hospital this may make it particularly important for hospitals to attract key consultants.
46. A new entrant may be reluctant to build a new hospital without first obtaining the commitment of insurers that they will include the facility on their network once it is built (financing may also depend on insurer recognition). However, we understand that insurer recognition could depend on whether the new hospital has attracted a reasonable range of consultants.
47. In addition, an incumbent hospital operator could deter consultants from committing to switch to a new entrant, or even committing part of their time to the proposed hospital, and hence it could prevent entry from occurring. In relation to the response of the incumbent hospital operator, financial incentives may be a common tool used to retain consultants or to encourage them to focus their work at a particular hospital operator's hospital.

48. An incumbent hospital operator with market power may also have other mechanisms to discourage consultants from switching to new entrants. Where a hospital has market power in a particular area, local consultants may also have a limited choice of hospitals where they can practice. Given that there is often a long lead time between planning to enter a market and actual entry, the incumbent may be in a position to place restrictions on its consultants that discourage them from committing to work at the new entrant.

#### *GP incentives (paragraph 44(c))*

49. The OFT reports<sup>18</sup> receiving evidence that some GPs may have been provided with incentives in return for referring patients to a particular hospital operator.<sup>19</sup> GPs appear to play a critical role in assisting patients in selecting the most appropriate consultant and hospital. Where a hospital operator with local market power is involved in incentivizing GPs in this way it could restrict the ability of a new entrant to attract patients based on clinical need or the quality of facilities. This may also arise if a consultant with local market power similarly provided incentives to GPs.

#### **5(c) other barriers to entry into the provision of privately-funded healthcare services**

50. There may be other potential barriers to entry that make construction of new private hospitals difficult:
- (a) Capital requirements and sunk costs: for example, the potentially high capital cost of new hospitals combined with the high exit costs deriving from the limited alternative uses for hospitals may be a barrier to entry. We note that this may vary depending on the type of facility and the types of treatments provided.
  - (b) Planning delays and the strategic use of the planning regime by incumbents may significantly delay the construction of new facilities.

#### **5(d) barriers to entry into the provision of consultant services in private practice**

51. Theory of harm 2 hypothesizes that consultants may have market power in certain local areas. In part this may derive from a shortage of consultants in these local areas or from the existence of consultant groups collectively setting their fee. This theory of harm is closely related to theory of harm 2 and hypothesizes that there may be barriers to entry into the provision of consultant services in private hospitals that may prevent new consultants entering in response to the high prices and thus protecting the market power of incumbents.

#### **Theory of harm 6: limited information availability**

52. This theory of harm argues that information asymmetries and the limited information available to patients (as well as GPs and possibly insurers) may distort competition as they limit a patient's ability to make an informed choice about the most appropriate hospital/consultant for their condition.

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<sup>18</sup> *Private Healthcare Market Study, OFT1412, April 2012*, paragraphs 8.78 & 8.79.

<sup>19</sup> We note that this may be in breach of British Medical Association Guidelines on GP conduct.

53. Limited accessible, standardized and comparable information appears to be available that could assist either patients or their GPs (and possibly insurers) to select the most suitable consultant and/or hospital. In particular:
- (a) There appears to be limited comparable information on either price or quality that self-pay patients could use in order to choose the consultant and/or hospital that best meets their requirements.
  - (b) Insured patients are less likely to focus on price at the point of selecting which hospital/consultant to use. This is because of the separation between those paying for the treatment and those who decide on the need for treatment. However, they do have an incentive to select the hospital/consultant based on the quality of the services provided. There appears to be limited comparable information on quality that would enable them or their GPs to make an informed choice as to the most suitable consultant and/or hospital to meet their needs. In relation to price, the limited information on the quality of care provided by consultants also means that insured patients cannot judge the value for money offered by agreeing to pay a top-up fee directly to a consultant if the charges exceed what the insurer is willing to pay. On the other hand, if insurers were able to direct their insured patients to recognized consultants (eg through 'managed care'), there appears to be a risk of patients being directed to cheaper rather than better consultants due to information asymmetries between patients and insurers.

#### *Effects of limited information being available to patients*

54. The limited information available to patients may compromise the patient's (and GP's) ability to choose the best hospital/consultant for their condition and, as a consequence, may result in:
- (a) GPs' recommendations relying on informal information and relationships, which may in turn strengthen the position of incumbents. This could lead to consumers paying higher prices or receiving lower quality services;
  - (b) a reduced incentive for hospital operators/consultants to compete aggressively to attract patients directly on the basis of either price or quality;
  - (c) higher search costs for: (i) self-pay patients when seeking to compare the breakdown of treatment costs in different hospital operators' hospitals; and (ii) all patients when seeking to choose a consultant and hospital operator; and
  - (d) higher search costs for GPs when making a referral.

#### ***Theory of harm 7: vertical effects***

55. The only insurer that is vertically integrated is BUPA, through ownership of the Cromwell hospital in London. BUPA and possibly some of the other insurers may also own some primary care facilities.
56. At this stage we do not believe that these vertical linkages are likely to lead to significant harm to competition. However, we are keeping an open mind to any potential vertical theory of harm as we learn more about the market.

## Possible detriment

57. We will seek to identify any detrimental effect(s) on patients which might result from any AEC. These could take the form of higher prices or privately-funded healthcare services that may be less suited to the patients' needs, reduced service quality, reduced choices of service and supplier and reduced innovation.
58. If we provisionally conclude that there is an AEC, then in considering remedies we will also consider whether any relevant customer benefits arise from the features that prevent, restrict or distort competition, within the meaning set out in paragraphs 4.26 to 4.31 of CC3.