COMPETITION COMMISSION

# PRIVATE HEALTHCARE MARKET INVESTIGATION

## Summary of provisional decision on remedies

**Notified: 16 January 2014**

1. This document presents our provisional decision on the package of remedies required to remedy the adverse effects on competition (AECs) and resulting customer detriment that we have provisionally found. The provisional decision on remedies and its accompanying appendices provide a basis for further consultation. We invite views in writing on this provisional decision on remedies by 5pm on 6 February 2014. A small number of parties have been asked to attend a meeting with the CC following this deadline.

2. Our provisional decision on remedies is based on our provisional findings which were published in summary form on 28 August 2013 and in full on 2 September 2013. These found that there were structural and conduct features which on their own and in combination gave rise to AECs in the provision of privately-funded healthcare services in the UK. The two structural features we identified were: *(a)* high barriers to entry and expansion for full service hospitals and *(b)* weak competitive constraints in many local areas including central London. We considered that together these two structural features led to higher prices for self-pay patients in certain local markets and to higher prices for insured patients for treatment by those hospital operators (HCA, BMI and Spire) that have market power in negotiations with private medical insurers. In addition, we found conduct features that give rise to AECs, namely the operation of incentive schemes by private hospital operators to encourage patient referrals by clinicians, a lack of sufficient information on the performance of private hospitals and a lack of information on the performance and fees of consultants. In the provisional findings, the customer detriment caused by the market power of HCA,

BMI and Spire was conservatively estimated within a range of £173 million to £193 million a year between 2009 and 2011.

3. The provisional decision on remedies takes account of our consideration of the evidence we have received from written responses to our Notice of possible remedies (Remedies Notice) which was published on 28 August 2013, our divestment options paper which was provided to the five largest hospital groups and three largest private medical insurers, response hearings with parties to this investigation, and their further submissions of evidence.

4. We have not, at this stage, made a final decision regarding the existence and form of any AEC and/or resulting customer detriment. Our provisional decision on remedies therefore proposes remedies that address the AECs as set out in our provisional findings with the exception that we have reviewed the applicability of the AECs to local markets where divestiture was proposed in our Remedies Notice in the light of parties' submissions and further analysis. Our final decision on any AECs, and appropriate remedies, will take into account all evidence received and submissions made including the responses to our provisional findings and provisional decision on remedies.

5. We have provisionally decided on a package of remedies that consists of five elements: *(a)* divestiture of nine private hospitals;[1] *(b)* review by the OFT/CMA of arrangements under which private hospital operators enter into agreements to operate private patient units (PPUs) in NHS hospitals and prohibition of such arrangements if they fail a competition test; (*c)* prohibition of or restrictions on certain clinician incentive schemes that encourage patient referrals to particular facilities or for particular treatments or tests; *(d)* requiring the collection and publication of

[1] We take 'hospital' to mean the assets that a new owner of the hospital would need in order to compete with the retained business.

information on the performance of private hospitals and individual consultants; and *(e)* requiring that private hospital operators include as a condition of granting practising privileges an obligation on consultants to provide fee information to patients using standard letter templates and that private hospital operators ensure that consultants comply with the obligation.

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

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

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

*(a) Divestiture of hospitals*

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

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

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

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

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

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

clinicians, any payments made to clinicians in return for services[3] and details of any clinicians practising at their hospitals who own equity in any of their facilities including in equipment.

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

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

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

*(e) Providing consultant fee information*

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

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

consultants. In combination with the remedy on consultant performance information, this would allow patients to choose a consultant who offers the best value healthcare, thus stimulating competition to attract patients.

8. Following consideration of parties' responses to the Remedies Notice and our own further analysis, we have also decided not to proceed with particular remedies outlined in our Remedies Notice regarding preventing tying or bundling by hospital operators and imposing price controls on hospital operators.

9. We have provisionally concluded that our proposed package of remedies is capable of effective implementation, monitoring and enforcement and that the package of remedies will have a substantial effect on the AECs in the short term and this effect will grow in the longer term.

10. We consider that our proposed package of remedies represents as comprehensive a solution as is reasonable and practicable to the AECs. Our package of remedies would address the AECs by reducing local concentration through divestitures, facilitating entry and expansion through PPUs and enabling rivalry between private hospitals and between consultants on the basis of the price and quality of services provided to patients rather than, for example, the benefits they provide to clinicians or referral patterns based on inadequate price and/or performance information.

11. Individual remedies should not be viewed in isolation but as part of a complimentary package of remedies to address the AECs. Our information remedies work together with our structural remedies by providing patients and others involved in the referral pathway with adequate information on performance and price to enable patients and others effectively to weigh price and, for example, travel time against quality. The PPU remedy will assist in increasing the competitive constraints on existing private

hospital operators in any local areas where an NHS Trust wishes to partner with a private hospital operator to operate a PPU. Without the remedy on clinician incentives, the PPU remedy (and the divestment remedy) might be frustrated through the use of incentives to retain in particular consultants.

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

13. In view of the above, we have therefore provisionally concluded that our proposed package of remedies represents as comprehensive a solution as is reasonable and practicable to the AECs and resulting customer detriment that we have provisionally found.