PRIVATE HEALTHCARE MARKET INVESTIGATION

Hospital competition for clinician referrals

Introduction

1. One of the ways that private hospitals compete is by encouraging consultants to treat at or refer private patients to their facilities. As most patients are referred to consultants by GPs, hospitals may also compete for patients by encouraging GPs to refer patients to consultants who use their hospitals.

2. Hospitals may encourage consultants to use their facilities in a variety of ways, within the constraints that the General Medical Council's (GMC's) rules impose.[1] They may 'market' themselves to consultants (or GPs) through communications, stressing the quality of their staff and the facilities and equipment that they have invested in. They may offer access to resources which will make using their hospital more convenient for a consultant than a rival facility, for example making consulting rooms or secretarial services available. They may also operate schemes which provide financial benefits to consultants using their facilities.

3. The purpose of this paper is to set out the various ways in which hospitals have sought to encourage consultants to use their facilities and to consider whether any or all of them may:

   (a) prevent or restrict entry or expansion of a rival hospital by obliging or incentivizing consultants to practise exclusively or predominantly at, or to refer or admit patients exclusively or predominantly to, that hospital provider's facilities rather than the entrant's; or

[1] These are contained in the GMC's Good Medical Practice and associated guidelines (2013): www.gmc-uk.org/guidance/good_medical_practice.asp.
These include guidance on honesty in financial dealings, including that a doctor must not allow any interests to affect the way they prescribe for, treat, refer or commission services for patients and that in the case of a conflict of interest the doctor must disclose his interest.

(b) give rise to information asymmetries between the doctor and the patient which may distort the market for private healthcare, for example patient awareness of whether a consultant has any financial interest in a private hospital or clinic.

Schemes adopted by hospital groups

4. We set out below a description of current or recent schemes adopted by hospitals and hospital groups to encourage referrals by GPs to consultants practising at their hospitals or to attract or retain consultants practising at their hospitals.

BMI

GPs

5. BMI told us that, currently, it only made payments to GPs for private GP services provided in its hospitals, ie BMI subcontracts services to GPs and pays them for those services. It said that it had considered GP incentive schemes in the past but had decided not to implement these proposals following legal review. Among the schemes it considered was one which it was proposed to pilot in Bath and Coventry.

6. BMI did operate a pilot scheme in Bath, commencing in 2010, whereby it made payments to GPs for preoperative assessments on BMI patients. It told us that the programme was designed to increase patient referrals through improved patient service by making pre-assessment more convenient. Under the terms of the scheme, where patients were referred to the Bath Clinic for an outpatient consultation and it was determined that surgery was necessary, a preoperative assessment (which would otherwise be carried out at Bath Clinic) was booked with the referring GP. The GP would be paid according to the type of assessment they undertook, with payment being dependent on the patient completing their care pathway at the Bath Clinic. Between six and eight local GP surgeries joined the scheme.

7. We asked PHPs whether they had, in the last six years, any arrangements in place whereby GPs or other primary care providers would prioritize referrals to their facilities. BMI told us that it previously had in place an arrangement with [✂].

8. It told us that it also had in place an arrangement, no longer active, with [✂].

9. BMI told us that it operated the BMI Syon Clinic as a corporate joint venture (JV) (ie a separate company) with Sentosa, a company comprising primarily consultants and GP shareholders. The Syon Clinic offers diagnostic and outpatient facilities provided by the consultants based there. [✂], Sentosa consultants at the Syon Clinic refer all their patients from the Syon Clinic requiring inpatient care to BMI facilities, and, where tests could not be undertaken at the clinic, to a BMI facility, subject to the GMC rules on Good Medical Practice. BMI told us that the corporate JV with Sentosa which had established the BMI Syon Clinic had helped move work from [✂].

10. We asked PHPs for details of any assets that they owned or rented where GPs or other primary care providers practised. BMI gave us [over 20] examples of such arrangements, mainly operated at its hospitals, and told us that, in addition, it had some BMI outpatient facilities in GP surgeries.

Consultants

11. BMI told us that in early 2012, before the Office of Fair Trading's (OFT's) Market Study Report decision, it had considered its position in relation to consultant incentive schemes. It wished to ensure that it was not engaging in schemes that could make the company vulnerable to media or regulator criticism, notwithstanding the eventual view that the CC took on the merits or demerits of these schemes. It decided to stop direct financial incentive schemes and profit-share arrangements other than where these related to joint investment or similar between the consultant and the hospital.

Nonetheless, BMI told us that in an environment where competition for consultants was fierce and consultants represented a significant source of work, legitimate grounds arguably did exist for payments to consultants by hospitals. It noted that it had not withdrawn from consultant arrangements that directly supported investment in particular JVs or co-investment vehicles.[2] BMI said that it did not consider these to be 'incentives' at all; rather they were necessary pro-competitive terms to support hospital investment and to bring into existence a shared desire between consultants and hospitals to develop new and enhanced patient services.

12. BMI supplied the CC with a review of Consultant Loyalty Schemes that it said had been prepared as part of its business operations [✂].

13. BMI group management considered consultant loyalty schemes in 2007 as part of its strategic response to increased competition from other hospital operators, including Circle. A board paper of April 2007, a month after Circle obtained planning permission for its Bath hospital, assessed the severity of the competitive threat to each of its hospitals. [✂] and Bath were considered to be exposed to the highest risks and, accordingly, were proposed as the first hospitals where consultant loyalty schemes would be set up.

14. The 'Mark 1' scheme combined profit sharing and 'virtual equity' elements which aimed to engage and motivate current and future [✂]. The scheme was designed in part to mimic an equity share plan [✂].

[2] For example, it told us that BMI Beardwood invested in a new cancer treatment centre through a joint venture with a number of consultants [✂].

15. The scheme covered a six-year period and entitled consultants to a share of the Bath Clinic's profits, the size of their entitlement being determined by the amount of revenue that a consultant brought to the hospital.[3] [✂]

16. As well as the rolling share of the Clinic's profits and the long-term payment referred to above, consultants would be entitled, depending upon their level of membership, to receive some or all of: [✂].

17. In addition to these benefits, if a member were to introduce a new consultant to the clinic who subsequently went on to enter into a similar agreement, then the introducing member/consultant would be entitled to [✂].

18. The 'Mark 1' scheme was, unlike Mark 2, contractual. [✂]

19. Consultants were also required to agree that they would not enter into any form of agreement or contract with any competitor relating to operation of a private medical practice including acquiring any financial interest in such a competitor, although they could retain practising privileges elsewhere.

20. The Mark 2 scheme was adopted in 2010 and [✂].

21. There was, unlike Mark 1, no formal contract with consultants, [✂]. The Mark 2 scheme also differed from Mark 1 in that there were no bars to participation, [✂].

Cost of the schemes

22. We show below the payouts from [✂] and Bath Clinic schemes.

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[3] [✂]

TABLE 1 **Consultant loyalty scheme payouts at [✂] and Bath Clinic**

£

	FY10	*FY11*	*FY12 est*
[✂]	[✂]	[✂]	[✂]
Bath			
Mk1	[✂]	[✂]	[✂]
Mk2	[✂]	[✂]	
Total	[✂]	[✂]	[✂]

Source: BMI.

Spire

GPs

23. Spire told us that several Spire hospitals had agreements with GPs for the provision of services of various sorts, including advising on marketing to GPs and health screening, room rental for consultants visiting GP practices and facilities for advertising the relevant Spire hospital. Spire provided us with a list of these services and where they have been put in place. Generally, the value of these arrangements to GPs was low, a few thousand pounds a year.

Consultants

24. Spire told us that it had no schemes providing incentives to consultants, either at a national or at individual hospital level, and to the extent that arrangements might exist which might be considered as offering such incentives, these would have been negotiated between the consultant and the relevant hospital director, may have arisen out of custom and practice and may not necessarily be recorded in writing.

25. Spire noted that arrangements with consultants could also sometimes take the form of JVs to introduce or expand a new procedure, service practice area or, as in the case of Spire Brighton, extend to the establishment of a new hospital.

26. It told us that Spire Brighton (the Montefiore Hospital) would be operated by a JV company (Montefiore House Limited). Spire had subscribed £[✂] in equity in return for which it had received a [✂] per cent share of Montefiore and the group of orthopaedic consultants and physiotherapists had subscribed £[✂] in equity in return for which they would receive a [✂] per cent share of Montefiore. The shareholders agreement would commit the consultants to the hospital for five years.

27. Spire listed the schemes that it operated and told us that most of them involved discounted consulting room rental or secretarial fees which it said were not linked to the volume or value of business that the consultant brought to the hospital nor to the proportion of their work that was undertaken at a Spire hospital.

28. We examined the arrangements that Spire set out in its submission. At Spire's [✂] hospital, for example, the majority of the arrangements listed related to discounted room rentals and secretarial services. Some, however, involved quite significant payments to consultants.

29. Under one, the hospital paid the Medical Defence Organisation (MDO) costs of a surgeon as well as providing the surgeon with free medical secretarial services and consulting rooms. The payment of their MDO costs, Spire told us, was in return for them committing their practice and referrals to the hospital, subject to the clinical interests of the patient, compliance with applicable codes of practice of the BMA and GMC and other than where a patient's insurer does not recognize the Spire hospital for care, diagnosis or treatment. Spire told us that the annual value of payments to this consultant between 2009 and 2012 had amounted to £[✂].

30. Another scheme at [✂] paid three consultants a proportion of the profit made by the hospital from cardiology tests referred to the hospital by the consultants. In 2011 this

scheme paid out just over £[✂] to each of the consultants. Spire told us that this arrangement pre-dated its ownership of the hospital [✂].

31. Spire told us that in a small number of cases a consultant or small group of consultants had agreed to base their private practice exclusively at a particular Spire hospital. At its [✂] hospital, for example, it had established the [✂],[4] equipped with outpatient consulting rooms, a CT scanning and MRI suite and two operating theatres with laminar flow. Spire pays the [✂] a fee based on the revenue generated by the [✂] consultants. It told us that its total payments since January 2009 to [✂] amounted to £[✂].

32. Spire told us that the agreement with the consultants provided carve-outs for them to treat patients elsewhere if so required by the GMC guidelines or if the patient expressly wished to be treated elsewhere.

33. Similarly, it told us that it had acquired the orthopaedic surgery practice of [✂] whose private practice work was now exclusive to [✂] and who now referred private patients to the hospital 'subject to the patient's clinical best interests'. Between 2010 and the first half of 2012, payments to [✂] amounted to just less than £[✂] based on the share of the revenue generated by his practice and that of his colleague in the [✂] unit [✂].

HCA

GPs

34. HCA provided us with a description of the arrangements each of its hospitals has with GPs where these exist.

[4] The [✂] consultants operate outpatient clinics at the [✂] and the [✂] hospitals.

35. HCA told us that it had a three-year Fully Managed Practice (FMP)[5] agreement with [✂] to provide professional medical services at its Wellington Hospital, in return for which he was paid £[✂]. [✂] also had an equity stake in the Wellington Diagnostics & Outpatient Centre (WDOC) JV in Golders Green.[6] HCA told us that the payments to [✂] represented fair market value for the services that he provided to the WDOC.

36. Also at the Wellington Hospital, HCA has a recruitment agreement with [✂] for the establishment of a private GP practice at the Wellington Hospital. HCA offered [✂] an income guarantee in the form of a loan to facilitate switching [✂] practice to the Wellington Hospital's Platinum Medical Centre. In the event, since [✂] income has not fallen below the guaranteed level, this facility has not been drawn down.

37. The Harley Street Clinic pays a retainer of £[✂] per year to [✂] under a Professional Services Agreement in [✂] capacity as [✂] of the New Malden Diagnostic Centre.

38. HCA told us that although these types of arrangements originally included obligations upon doctors to use their best endeavours to refer patients to HCA facilities, following a review in 2011/12 contracts have been reworded so as to remove this obligation and make clear that doctors, having signed a PSA for example, 'shall be under no obligation to refer patients to any [HCA] hospital'.

39. In addition to these arrangements, HCA has a number of Consulting Room Licence Agreements (CRLAs) with GPs who operate their practices at HCA facilities. It told us that consulting rooms were licensed out at the WDOC and Platinum Medical Centre and that consulting rooms were licensed to two GPs at the Harley Street Clinic Diagnostic Centre. The Lister Hospital owns two facilities where it licenses consulting

[5] We explain FMPs and the other agreements used by HCA more fully in our discussion of HCA's arrangements with consultants.
[6] 25 private GPs operate from the WDOC, www.wellingtondiagnosticscentre.com/.

rooms to GPs (the Chelsea Consulting Rooms and the Chelsea Medical Centre), the London Bridge Hospital provides facilities for two GPs at its Medical Centre in Sevenoaks and for one at the City of London Medical Centre and the Princess Grace Hospital provides facilities for four GPs in a facility located in front of the hospital.

Consultants

40. HCA told us that it had six types of agreement that it could offer consultants. Under its CRLA consultants are provided with consulting rooms at HCA facilities for which the consultant pays a 'fair market value' other than in circumstances such as a consultant coming new to HCA in which the fee may be waived for up to six months. It said that about half of the 3,000 consultants with practising privileges at HCA facilities had CRLAs, which, it noted, contained no obligations on consultants to refer patients to HCA facilities.

41. FMP agreements, it said, related to clinical units which HCA wished to establish, develop or strengthen. Consultants were paid a fixed annual fee for their services and, though HCA and the consultants may agree certain growth targets for the unit, no bonuses were payable if they were met. Under the current contract, consultants were not obliged to refer patients to HCA facilities but must always refer on the basis of the patient's best interests and, in line with the draft FMP Handbook, must disclose their financial interests to patients. HCA told us that it had entered into 28 FMPs covering around 130 consultants and 21 of the 28 agreements contained growth plans.

42. Professional service agreements (PSAs) are agreements between HCA and a consultant for the provision of clinical services, for example a medical directorship at an HCA hospital. Consultants are paid a fixed annual fee for their services based on an hourly rate and the number of hours that the consultant is expected to devote to the work involved. Again, under the current contract consultants are not requested to

refer patients to HCA hospitals. HCA gave an example of this type of agreement whereby a consultant was to supply neurology services at the Harley Street Clinic with an annual growth target of 10 per cent in new outpatients. HCA has entered into 141 PSAs covering around 170 consultants.

43. Recruitment agreements (RAs) have the objective of attracting consultants to an HCA facility. The consultant is expected to work with HCA to manage and grow their practice at an HCA hospital. HCA told us that these agreements might be offered to consultants relocating their practices and thus facing increased costs or risking losing patients; the consultant is in their first year of private practice; or the consultant wishes to reduce their NHS workload in favour of private practice. Under these agreements HCA may offer the consultant an income guarantee or a loan to cover start-up expenditure. Only ten such agreements are in place and HCA told us that it was in the process of phasing them out.

44. Recruiting agreements provide consultants who already have an FMP with additional resources to attract new or junior consultants to assist the consultant in developing the unit concerned. HCA may provide the consultant with a loan which he or she may use to fund an income guarantee for the new consultant, for example. HCA has 12 such agreements in place.

45. Galen consultant agreements (GCAs) are agreements between Galen Health Partners (a wholly-owned subsidiary of HCA) and consultants or a company of consultants under which Galen procures certain support services on behalf of consultants such as practice management, practice marketing and financial services. HCA currently has 143 Galen agreements in place.

46. The number and cost of these various arrangements was set out in HCA's 2012 business plan (2011). In total these costs amounted to around £5 million a year.

FIGURE 1

HCA's consultant engagement schemes

Source: HCA.

47. HCA told us that in 2011/12 it reviewed its contracts with consultants for compliance with the Bribery Act and GMC guidelines. It told us that these (original) contracts obliged consultants to use their best endeavours to refer patients to HCA facilities but always subject to the clinical needs and best interests of the patient.

48. However, HCA told us that it wished to remove any potential conflict of interest and so reworded its contracts to state explicitly that consultants party to the agreements we have just summarized were under no obligation to refer patients to HCA hospitals. Letters to doctors explaining the need for the changed wording and also obliging

doctors to disclose to patients their financial interest in the unit were sent out in the first half of 2012.

49. HCA told us that in addition to these arrangements it had entered into a number of JV agreements with consultants for certain outpatient facilities. The model for these JVs is that HCA will obtain a suitable site for the clinic and sublet it to the LLP. It will provide management services to the LLP in return for a fee of [✂] and the LLP charges consultants a fee for the use of consulting rooms. In all cases HCA is the majority owner of the business with shares ranging from 51.5 per cent (the Chelsea Outpatient Centre) to 90.4 per cent (the LOC Partnership LLP).

50. The original agreements underlying these arrangements included obligations as regards referrals to HCA hospitals, though with caveats with reference to patients' best interests.

51. The 2011 LLP agreement for the LOC obliged members to use their reasonable endeavours to refer their own patients who were seen at the LOC Centre and who required inpatient care to HCA facilities, 'subject always to the patient's clinical needs and best interests'.

52. The LLP agreement relating to the Chelsea Outpatient Centre LLP similarly obliged members to 'use best endeavours to refer all patients of the Member, who are seen at the Centre and who require in-patient treatment to an HCA hospital subject always to the clinical and best needs of the patient'.

53. HCA told us that just as it had reviewed its service agreements for compliance with the Bribery Act and GMC guidelines it did so for its JV agreements. As a result of this review the 'best endeavours' obligation to use HCA facilities wording was changed so

that members undertook not to be influenced by the terms or the existence of the JV agreement in their choice of treatment or treatment facility recommended to patients.

54. We note that the varied agreement does include an undertaking that the member will 'use his reasonable endeavours to utilise the facilities of the Centre for the purpose of developing his private practice' again though 'subject always to the patient's clinical needs and best interests'. Members thus have, subject to the 'patients' best interests' caveat, an obligation to use the relevant centre operated by the JV, in which they have an equity stake, but not to refer patients on to facilities operated by HCA.

55. HCA pointed out that these JV agreements in some cases incorporated non-compete obligations, for example that governing the CyberKnife treatment facility which prevents a consultant member of the JV holding an ownership interest in another business engaged in radiosurgery or other services provided at the CyberKnife centre. HCA pointed out that this clause did not limit the right of the consultant to practise at another private or NHS facility. It told us that in the light of the substantial investments made and market risks faced by HCA, it considered these non-compete obligations to be entirely reasonable, proportionate and necessary. We note that 'non-compete' terms are contained in the LOC LLP agreement whereby member consultants are precluded from offering outpatient (though not inpatient or day-case) services at rival facilities within a 10-mile radius.

Nuffield Health

GPs

56. Nuffield Health (Nuffield) told us that it had not in the last six years and did not currently have any arrangements in place with individual GPs, GP practices or other primary care organizations to prioritize referrals into its facilities and nor did it have any plans to do so in the future.

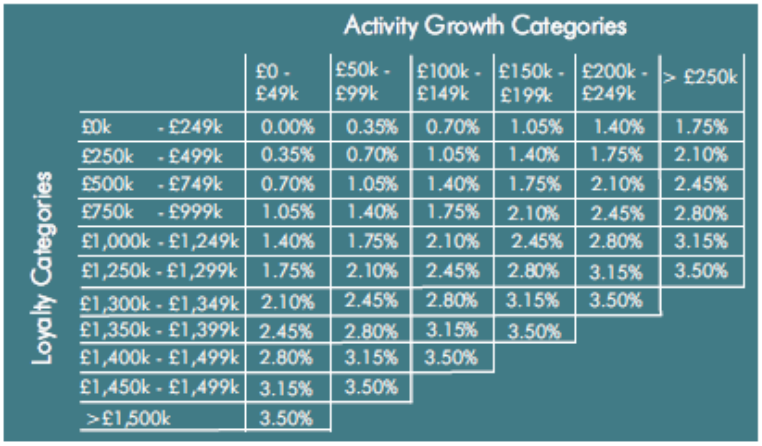
57. Nuffield provided us with details of premises that it owned where GPs currently practised and the terms on which these were provided. It told us that GPs practised at its Bournemouth, Brentford, Bristol, Derby, Guildford, Haywards Heath, Leeds, Oxford and Woking hospitals. It said that arrangements varied but that the most common was that facilities were not provided free and the hospital took a share of the fees generated by the GPs concerned.

Consultants

58. Nuffield told us that in 2009 it introduced a national reward programme for consultants called Practice Privileges Plus (PP^+). Nuffield told us that the paramount aim of the scheme was patient care, that consultants were not precluded from working elsewhere and that the scheme was intended to be funded from economies of scale arising from increased business growth. Payments under the scheme were calculated on the amount of revenue that the consultant had generated and revenue growth in the current year. Thus the more revenue a consultant had generated previously the more he could earn from the scheme, and the greater his growth on prior year the bigger the payout, up to a maximum of 3.5 per cent of the gross value of the consultant's earnings for the hospital the year previously. The grid for payments is reproduced in Figure 2.

FIGURE 2

Nuffield Health's PP+ Scheme Payout Grid



Loyalty Categories	Activity Growth Categories					
	£0 - £49k	£50k - £99k	£100k - £149k	£150k - £199k	£200k - £249k	> £250k
£0k - £249k	0.00%	0.35%	0.70%	1.05%	1.40%	1.75%
£250k - £499k	0.35%	0.70%	1.05%	1.40%	1.75%	2.10%
£500k - £749k	0.70%	1.05%	1.40%	1.75%	2.10%	2.45%
£750k - £999k	1.05%	1.40%	1.75%	2.10%	2.45%	2.80%
£1,000k - £1,249k	1.40%	1.75%	2.10%	2.45%	2.80%	3.15%
£1,250k - £1,299k	1.75%	2.10%	2.45%	2.80%	3.15%	3.50%
£1,300k - £1,349k	2.10%	2.45%	2.80%	3.15%	3.50%	
£1,350k - £1,399k	2.45%	2.80%	3.15%	3.50%		
£1,400k - £1,499k	2.80%	3.15%	3.50%			
£1,450k - £1,499k	3.15%	3.50%				
>£1,500k	3.50%					

Source: Nuffield Health.

59. In 2012 Nuffield decided to close the scheme. It told us that the scheme had been designed so that additional incentives would not be required. However, hospitals were continuing to provide free consulting rooms, free telephone use, secretarial services etc on top of the benefits of the PP+. It said that these practices varied by hospital so were not easy to quantify and also risked negating the model rewards as those who did not earn a financial reward could receive benefits in other ways. It said that, in addition, doctor groups were being formed and in some cases engaging with management companies to negotiate on their behalf and therefore individual deals were being struck outside the PP+ contract.

60. The document setting out Nuffield's analysis of the scheme indicated that the current regulatory interventions may have contributed to the decision to review and cease the PP+ scheme. The report concluded:

> However, the current climate emanating from the OFT investigation indicates that continuation of the PP+ programme is not sustainable. Nuffield Health has stated publicly that 'We would like a ban to be considered on any form of financial incentive to consultants and GPs

from private healthcare organisations. We believe this will help improve the service consumers receive by providing greater choice and easier access to the right healthcare professionals to suit their needs.' Nuffield Health has established a position on such incentives. A decision to delay the removal of PP+ would be counter to this positive stance and create the appearance that any decision to remove PP+ in the future was reactive to any future announcement by the OFT or the Competition Commission (CC).

The recommendation is that PP+ contract termination is served soon as possible to meet the likely announcements regarding such incentive packages by the OFT or CC and in line with David Mobb's [group CEO] statement to the Times on 24th February 2012; with the effect of our maintaining our ethical stance on the subject and raising the spotlight on competitor practices.

Ramsay

GPs

61. Ramsay told us that it did not agree with offering direct financial incentives to GPs or other providers of primary care and did not make such incentives available. However, it regarded the role of GPs as sources of patient referrals as very important and that strong relationships with GPs were critical to its business success. It said that each of its hospitals employed a GP Liaison Officer who would regularly visit GP practices, inform practitioners about developments at Ramsay hospitals, introduce GPs to Ramsay consultants, discuss any issues with previous referrals and get feedback from GPs. It said that the only payments that it made to GPs were in return for services provided in attendance at its neurological rehabilitation units.

62. Ramsay told us that private GPs operated out of some of its hospital facilities. At its Springfield hospital, for example, a group of private GPs rented two consulting rooms, an office plus reception and waiting area. The hospital charged the GPs £[✂] per month for the use of these facilities which included the cost of employing two reception staff. Ramsay said that save for a free room provided at its West Midlands Hospital to support the NHS Abdominal Aortic Aneurysm screening programme, it did not provide any free or subsidized accommodation or services to GPs.

63. Ramsay told us that it strongly believed in the importance of GP education and training and that its hospitals regularly hosted 'lunch and learn' events at GP practices at which a consultant with relevant expertise would present on a topic of interest to GPs. In addition to these events, Ramsay told us that it organized educational seminars and workshops for GPs and practice employees and provided literature and reports, including information on the quality of the services at each of its hospitals.

Consultants

64. Ramsay told us that it had operated just two financial incentive schemes in the previous three years but that both had now been terminated and were only offered at Ramsay's Berkshire Independent Hospital.

65. Between January 2009 and June 2011 it operated a consultant revenue share scheme under which consultants received a payment equivalent to [✂] per cent of their outpatient revenues and [✂] per cent of their inpatient revenues each quarter. At the same time as it introduced this scheme it also ceased subsidizing medical secretarial services which, from then on, had to be paid for on a full recovery basis. Ramsay told us that the scheme had been introduced by the then Regional Director without approval from Ramsay's executive team, that it was not a contractual scheme and that a total of £[✂] had been paid out to consultants under it.

66. Ramsay told us that urology consultants, operating as Reading Urology Partnership, had a separate scheme which operated from January 2008 to June 2011 (when the Partnership moved their practice elsewhere). Under the scheme, which was non-contractual and initial discussions over which had taken place prior to Ramsay's acquisition of Capio in November 2007, the Partnership received a total of £[✂] in payouts.

67. Ramsay told us that there were various 'support/benefit' arrangements in place at its hospitals, for example room rental and secretarial services, but that it was for each hospital to determine the appropriate charge for these. It said that in the majority of Ramsay hospitals consultants paid the standard (non-discounted) room rental fee but that some of its hospitals discounted room rental or provided the consulting room free of charge for consultants who generated a high level of revenue for the hospital.

Circle

68. As we set out in our case study on Bath, Circle differs from its competitors in that it offers consultants who commit to undertake a given proportion of their work at a Circle hospital an equity stake in the business.

69. Circle Health Limited, the parent company of the Circle operating group, is 50.1 per cent owned by Circle Holdings plc and 49.9 per cent owned by Circle Partnership Limited. Circle Holdings is the entity through which capital is raised to fund the growth of Circle's activities and Circle Partnership is the entity through which clinicians and employees are granted share ownership in Circle.

GPs

70. Circle told us that in 2006/07 it had attempted to attract GPs to the partnership with a view to developing an integrated care model as practised in the USA. It said that the

attempt was abandoned once it was clear that it was not appropriate for GPs to have a substantial role in Circle's partnership as this would pose inherent provider-commissioner conflicts. It said that a relatively small number of GPs remained in the Circle practice but were not active.

Consultants

71. Circle told us that when it identified a particular market that it believed was viable, it met with consultants in the area. In exchange for building a new hospital in the area, the consultant was asked to commit a certain proportion of their private work, usually around 50 to 60 per cent, to the hospital. The consultant might terminate this contract with 12 months' notice after the first anniversary of the hospital's opening. Upon entering into this agreement the consultant typically received a small grant of Circle Partnership shares. Shares were offered to consultants at 'fair market value' determined annually by an independent valuer, though participants did not need to pay for them at the time of acceptance but only when they came to sell the shares.

72. Circle told us that consultants working at its facilities were encouraged to take responsibility for both the quality and the cost of care they provided through participation in the facility's executive board, which reviewed operational, clinical and financial performance and comprised clinical leads who were responsible to the board.

Other hospitals

73. In the course of researching our case study on the London Clinic's expansion in cancer treatment in London, we collected information on arrangements adopted by hospital operators to encourage consultants to use their facilities.

Bupa Cromwell Hospital

GPs

74. Bupa Cromwell Hospital (BCH) told us that its hospital site encompassed mews buildings, some of which were rented out to consultants and GPs. It said that there were [✂] private GP practices operating out of the mews with lease agreements. It said that the rental for this accommodation had previously been dependent on the value of referrals made to BCH under agreements reached prior to Bupa's ownership of BCH. BCH confirmed that it had removed the direct link in these arrangements between the office rental value and referral fees.

Consultants

75. BCH told us that it had operated schemes which provided consultants direct financial incentives to refer patients to the hospital.[7] These included a volume-related financial incentive scheme to encourage consultants to refer patients for [✂][8] and [✂] where consultants received payment for referrals into it. The [✂] scheme has now ceased.

76. BCH told us that, as with GPs, it had been the practice at the hospital to subsidize rates at which consultants were provided with consulting rooms. Figures supplied to us indicate that these subsidies were valued at just over £[✂] a year.

77. BCH said that since acquiring the hospital it had sought to rationalize and standardize its approach to consultant reimbursement but that currently using incentives was unavoidable to remain competitive in London if other hospitals were permitted to use them. However, it also expressed concerns regarding an 'arms race' developing between hospitals which, it said, would lead to the hospitals with the deepest pockets entrenching the relationships with consultants. It said that it had itself experienced

[7] In the first seven months of 2012 BCH spent £[✂] on what it described as 'clinical lead payments' where a consultant takes on the role of clinical lead for a speciality area such as cancer or cardiology. BCH told us that these roles required additional administrative and operational functions. Levels of payment were not related to volume of patient activity or referrals but were in return for undertaking clinical leadership and responsibility for governance and quality of service for a speciality.
[8] [✂]

the challenges of entering new services because it could not match the incentives offered by other large hospital operators in London.

The London Clinic

GPs

78. We are not aware of any arrangements between The London Clinic (TLC) and GPs.

Consultants

79. In our case study on TLC's Cancer Centre we reported an episode in which two consultants [✂][9] at the Clinic were contemplating transferring their practice to another hospital, believed by TLC management to be HCA's Platinum Centre at the Wellington Hospital. The Board of Trustees gave its 'exceptional'[10] permission to the management to come to an arrangement with the two consultants that would retain them.

80. The terms agreed included that the consultants concerned were under the following obligation: they should:

> use best endeavours to procure that all referrals and diagnosis requiring other treatments are carried out at the Hospital and not at any other institution including, without limitation, the London Oncology Centre (LOC) and HCA hospitals. This requirement will not apply if it is concluded by the Contractor or the Consultant that, for clinical reasons, it is in the best interests of the relevant patient for treatment to take place elsewhere.[11]

[9] In excess of £[✂].
[10] TLC told us that that was a 'one-off, defensive' arrangement.
[11] [✂]

81. We also reported in the case study that TLC had an agreement with the LOC which it had signed in 2005 which obliged the LOC, in exchange for a £[✂] loan from TLC, to refer patients to TLC. These obligations were quite extensive. Members were obliged to refer to TLC, and to use their best endeavours to cause all consultants working at the LOC, all new patients requiring inpatient admission and all outpatient and day-case patients who cannot be treated at LOC, for treatment at TLC. Similar obligations applied to the referral of patients for general radiology, ultrasound and CT/MRI and, when TLC was able to provide these services, PET scanning, all radiotherapy and nuclear medicine imaging. In addition, LOC was entitled to a £[✂] fee for each MRI scan undertaken by TLC arising from LOC referrals. These obligations were, however, subject to the 'patients' best clinical interests' caveat and subject to the GMC rules on 'Good Medical Practice'.

Conclusions

82. We found that schemes to encourage consultants to use their facilities were wide-spread geographically and that, for example, independent hospitals as well as groups had adopted them. We note, however, that such schemes tended to be more evident in parts of the UK or within clinical specialties where competition for consultants was stronger.

83. These schemes varied in nature, value and sophistication and could provide benefits either in kind or in cash. They ranged from seminars or communications to GPs stressing the features and benefits of a hospital's facilities, through relatively low-value, non-cash benefits to clinicians such as free or subsidized secretarial services, to schemes entitling consultants to, potentially, very significant financial rewards.

84. Schemes also differed as to whether or not the size of the benefit to which the clinician was entitled varied directly with the amount of business he or she brought to

the hospital. Schemes which entitled clinicians to benefits based directly on the volume or value of business they brought to the hospital became less common from 2011, coincident with the OFT's and subsequently the CC's intervention. We illustrate this categorization in Table 2.

TABLE 2 **PHP schemes to encourage referrals**

	Financial	*Non-financial*
Direct	Pay-per referral	Consulting room rental/licence fees set through a scale of charges linked directly to value of referrals/admissions
Indirect	Equity/shadow equity participation, JVs	Promotional material, seminars

Source: CC analysis.

85. We also note that PHPs have recently introduced new carve-outs and caveats to their agreements. These have increasingly stressed that the terms of the arrangement are at all times subject to the best clinical interests of the patient and that consultants are expected to comply with the relevant regulatory requirements, including the GMC Good Medical Practice guidelines.[12] In the case of one hospital group's schemes, the revised agreement goes so far as to state that neither its terms nor its existence give rise to any obligation on the clinician to refer or admit patients to its facilities.

86. We see two possible adverse effects on competition that might arise from some of the schemes that we have described here:

(a) they might create barriers to entry; and/or

(b) they might result in information asymmetry.

[12] www.gmc-uk.org/guidance/good_medical_practice.asp.

Barriers to entry

87. For such schemes to constitute a barrier to entry, they would have to prevent or deter *(a)* a sufficient number of consultants in *(b)* a commercially important specialty from practising at all or for a significant proportion of their time at the entrant's facility. In addition, the ability of the entrant to make such schemes available would have to be constrained relative to the incumbent's ability to do so.

88. We have seen no examples of contractual arrangements between PHPs and consultants that would prevent absolutely an individual consultant from working for a rival. In all cases, any such general obligations have been qualified by, for example, the overriding need to take account of the patient's clinical interest. However, and even with these caveats, such arrangements may, in practice, lead a consultant to work exclusively or predominantly at the PHP's facilities even if he or she were not prevented from working elsewhere by contractual obligations since to do so might be more convenient than 'multi-homing'.

89. We have also seen that such arrangements may be entered into with groups of consultants who are increasingly establishing 'chambers', partnerships or other business entities which enable them to deal with hospital groups jointly. In these circumstances it would be possible for a hospital operator to enter into agreements with a large proportion of local consultants in a particular, commercially important, specialty more quickly and easily than it could do if dealing with consultants individually.

90. However, we note that such strategies are available to the entrant as well as to the incumbent. We saw in Bath and Brighton, for example, that entrants Circle and Spire were able, respectively, to attract consultants through their, albeit differently structured, partnership schemes.

Information asymmetries

91. Clearly, patients are very unlikely to be as medically well informed as their consultants and will thus have to rely on them for expert and impartial advice. If that consultant is participating in a scheme which offers him or her incentives to, for example, admit patients to a particular hospital or to refer them for certain tests, even if patients are aware of this they may be uncertain whether the consultant has taken these incentives into account in making a recommendation. In these circumstances there will be asymmetry of information between the patient (the principal) and the consultant (his or her agent) which may give rise to distortions.

92. We have looked at schemes which, notwithstanding the caveats that they contain as regards the patient's clinical best interests, we believe may create a tension between the consultant's professional obligations and his or her commercial interests. Further, we think that this tension is likely to be more acute and of greater concern where the clinician is offered by the PHP incentives which vary in value directly with the volume of work that he or she generates for or at the hospital concerned than where there is a less immediate or obvious connection between action and reward.