



SPIRE HEALTHCARE

COMPETITION COMMISSION

PRIVATE HEALTHCARE MARKET INVESTIGATION

RESPONSE TO ISSUES STATEMENT

20 July 2012

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EXECUTIVE SUMMARY

Overview

1. UK patients can choose from a wide range of available healthcare options: at every step of the patient journey, they are faced with a highly competitive landscape. They can choose between NHS care (free at the point of delivery) and private healthcare provision. They can choose between different consultants, competing hospital providers and competing insurers to reimburse their medical costs.
2. Spire Healthcare (*Spire*) supports the Competition Commission's (*CC*) goal of ensuring that the UK private healthcare (*PH*) sector functions competitively. Consumers benefit from competition among consultants, PH providers (*PHPs*) and private medical insurers (*PMIs*) through:
 - (a) access to an ever increasing quality and range of services offered by consultants, PHPs, the National Health Service (*NHS*), NHS private patient units (*PPUs*) and PMIs;
 - (b) better clinical outcomes and improved patient experience;
 - (c) ongoing improvements in the value for money of products/services for both insured and self-pay consumers; and
 - (d) ultimately, a competitive PH environment as an alternative to the NHS.

Promotion of patients' interests

3. The crucial point is to view private healthcare from the perspective of the ultimate consumer, who is of course the patient (whether PMI or self-pay). A PH sector that promotes patient interests (through access to information and improving quality, service, price and choice) will also be in the interest of the supplier groups. As consumer benefits increase, more consumers are likely to decide to participate in the private healthcare sector, which will have direct benefits for the sector itself, as well as indirect benefits for the NHS through relieving the pressure on it at a time of static or declining funding.

Fully informed consent

4. The interests of patients will be best served by ensuring that at the start, and then at all following stages, of the PH treatment process they are given complete information about all aspects of their treatment, so that they can give fully informed consent. This is particularly so for financial aspects of the service, where Spire believes adoption of "informed financial consent" would benefit patients.
5. For PMI patients, this would mean:
 - (a) at the point of taking out PMI cover, provision of clearer information about the extent of cover and any excess, including cover for outpatient and diagnostic services;
 - (b) at the point of selecting a consultant and a PH facility, information about the quality of the available consultants and facilities including information about

clinical outcomes (e.g. infection rates, readmission rates) and patient satisfaction scores;

- (c) for any outpatient diagnostics, provision of clearer information about the cost of the services, whether they are covered by the patient's PMI policy, whether the patient can pay an additional amount (referred to either as a "shortfall" or a "top-up" payment) to attend a different facility and/or have a different diagnostic procedure, and the likely amount of any such shortfall/top-up payment;
 - (d) when making the decision of which consultant to see at the first referral, clear information about the cost of the initial consultation, whether it is covered by a PMI policy, whether the patient can pay a top-up fee to see a different consultant, and the likely amount of any such shortfall/top-up payment; and
 - (e) when making the decision to undergo a procedure, clear information about the cost of the procedure (including surgeon, anaesthetist and facilities), whether it is covered by the policy, and whether the patient can pay a top-up fee to change the surgeon, consultant or facility.
6. Similarly, for self-pay patients, this would include provision of:
- (a) at the point of selecting a consultant and a PH facility, information about the quality of the available consultants and facilities including information about clinical outcomes (e.g. infection rates, readmission rates) and patient satisfaction scores;
 - (b) for any outpatient diagnostics, clear information about the cost of the services;
 - (c) prior to an initial consultation, clear information about the cost of the initial consultation and the indicative cost of the procedure; and
 - (d) when deciding to undergo a procedure, clear information about the cost of the procedure and the services covered by a package price (including the fees associated with the surgeon, the anaesthetist and the facilities).
7. Spire summarises below its comments on the seven possible Theories of Harm identified by the CC.

Market power of hospital operators in certain local areas

8. In each local market, Spire hospitals are constrained by one or more of the following: existing competition from other PHs, PUs and the NHS; potential competition from other PHs, PUs and the NHS; and the buyer power of PMIs. Even if hospital operators in theory had a degree of local market power in certain local areas, such market power would only give rise to an adverse effect on competition if that market power resulted in either or both a failure to improve quality, range and availability of service sufficiently quickly or uncompetitive pricing. None of those outcomes is present in this case, because:

- (a) there is extensive evidence of dynamic competition between the PH sector participants. Spire has invested substantially in its hospitals to offer new and

more complex procedures to serve patients better and provide a competitive alternative to that of other PHPs and free NHS services. Traditional hospitals face competition from an increasingly wide range of different types of facilities (including single service providers), and there is a growing trend for PHPs to establish satellite consulting rooms to extend their catchment areas;

- (b) the NHS, through both its public and private healthcare provision, provides a genuine and material alternative to private healthcare, offering an alternative choice for patients at every step along the patient pathway and, therefore, imposes a very significant competitive constraint on the PHPs. As noted above, PHPs must distinguish themselves from the NHS in order to attract patients; and indeed Spire has invested substantially to do so;
- (c) there is an acknowledged overcapacity in the PHP sector which acts to constrain pricing both for PMI and self-pay patients;
- (d) PMIs can and do constrain PHPs due to their substantial buyer power; they can (and do) steer patients between different facilities (including the NHS) and consultants; they can (and do) delist one or more of a major PHP's hospitals and/or consultants that practice at those hospitals, and they have the ability and incentive to sponsor entry and growth by PHPs; and
- (e) concentration may be *caused* by effective dynamic competition where PHPs introduce new services not offered currently by their rivals and/or where hospitals offering the best patient service gain the highest local market share.

Market power of consultants or consultant groups in local areas

9. The CC will need to consider whether there are important quality benefits that accrue to the consumer (e.g. cover in the event of absence or emergency) from consultant groupings, which may outweigh any potential impact of such groupings on competition.

10. There may also be an argument that such groupings act as countervailing bargaining power to PMIs. This may benefit patients by preventing PMIs from suppressing consultant fee levels below competitive levels (for example through fee schedules that may provide an inadequate level of compensation), which could affect incentives to innovate and/or consultant entry.

Market power of private hospital operators during national negotiations with insurers

11. In dealings with the PMIs, the PHPs face a greater concentration than their own, including two very large PMI companies upon which Spire relies heavily to ensure its hospitals are economically viable. As the CC has noted¹, the four largest PMIs account for 87% of premium revenue; the two largest PMIs (Bupa and AXA-PPP) account for 66% of premium revenue. PMIs are able to use their bargaining power in a variety of ways to influence the patient pathway:

¹ Issues Statement, paragraph 13.

- (a) in particular by setting the location, timing and type of treatment, and the identity of the person giving the treatment;
- (b) by de-listing PH hospitals from their networks (including so called “solus” facilities); this is a significant threat to PH providers, who rely on a small number of PMIs for the majority of their revenues; and
- (c) agreements between PHPs and PMIs are enabling contracts only, and do not guarantee any volumes. Having gained access to a PMI network, a PH provider cannot take patient referrals for granted. Patients may choose to use other facilities and PMIs may, in fact, steer patients to different hospitals and consultants, in the private sector and in the NHS. PHPs must, therefore, continue to compete to attract and retain high quality consultants and to differentiate their hospitals both from other PHPs, PPUs and from the NHS alternative.

12. PMIs have a number of contact points in this medical circle, and so can determine:

- (a) the premiums for, and coverage of, policies;
- (b) how and when insured patients can claim;
- (c) the pre-authorisation required and, the PHPs and consultants to which insured patients have access; and
- (d) how much insured patients are reimbursed.

13. This allows certain PMIs to use a number of techniques to contain the costs of treatment, for example through the use of “managed care”, consultant fee reductions and other initiatives. To the extent that this results in the PMIs offering lower premia (leading to growth in the number of PMI patients), this should be a positive thing for the sector as a whole.

14. PMIs can use their bargaining power to facilitate competition among PHPs, and between PHPs and the NHS. Spire is concerned, however, that PMI attempts to control costs do not always serve the patient’s best interest.

15. In particular, as the OFT noted, the PMIs have adopted a range of tools to engage their bargaining power in the sector, many of which have themselves distorted competition, for example by restricting patients’ ability to pay top-up fees to access their preferred PH facility and consultant. Spire believes strongly that patient choice is paramount in this market and should not be limited by PMIs. Spire considers that other approaches (for example the ability for a patient to pay top-up fees combined with more information on the options available) would be more suitable and achieve an equal if not better outcome, and certainly one more in the control of the PMI patient.

16. In addition to the stated seven Theories of Harm, as the CC notes there is the risk that insurers may have a degree of buyer power over hospital operators, such that

insurers may exert too much pressure on the price paid to the hospital operator.² Such a situation could adversely affect competition and patient care, for example, by reducing investment in facilities and equipment by private healthcare providers and reducing the scope of services offered. Furthermore, as noted by the CC, if the market for private medical insurance is not competitive, lower prices paid by PMIs to healthcare providers may not be passed on fully to purchasers of insurance through lower premiums. Spire believes the issue of buyer power of insurers over hospital operators, which is in Spire's view the day to day reality of the sector, is one that does indeed merit further investigation by the CC.

Buyer power of insurers in respect of individual consultants

17. The PHPs do not set consultants' fee levels. Consultants set their fees independently. PMI companies have significant influence over consultant fee levels, with Bupa's reimbursement rates generally viewed as the industry benchmark.

18. The CC may wish to consider whether unilaterally-imposed fee cuts by Bupa (achieved apparently by virtue of its market power), when taken together with increases in consultants' costs of doing business (such as the rapidly rising cost of private medical indemnity) have impacted – or at some stage will impact – adversely on the supply of consultants willing to treat patients privately.

19. Spire agrees with the CC's view³ that there appears to be a risk of patients being directed to cheaper rather than better consultants, or to consultants perceived to have lower intervention rates, due to information asymmetries between patients and PMIs.

Barriers to entry

20. Any market (such as private healthcare) which requires significant committed capital expenditure to enter has by its nature some inbuilt barriers to entry. However, the extent and impact of any such obstacles has been overstated by the OFT: indeed, the suggestion that there are excessive barriers to entry is inconsistent with the extent of observable new entry, facility expansion, and service expansion.

21. The OFT also suggested other potential barriers to entry such as "one in, all in" contracts and restrictions on PMI network recognition. Spire emphasises that "one in, all in" contracts in practice benefit PMIs as they do not (at least in the case of Spire) prevent rival hospitals being recognised on PMI networks. Spire believes that the PH market would work best if all PH facilities were recognised by all PMI companies and thus could compete for patients on the basis of quality and price. Spire, therefore, does not support the development of restricted networks which limit recognition of new PH facilities and limit patients' ability to choose between facilities (for example through preventing the payment of top-up fees to attend a different facility).

² Issues Statement, paragraph 34.

³ Issues Statement, paragraph 53.

22. Any incentives that have the effect of influencing consultants to use one facility over another for a non-patient centred reason should be restricted or controlled, unless there is an attached benefit (such as the provision of new facilities or equipment) (i) which benefits consumers/patients and (ii) which, because of its cost, is unlikely to be provided without reasonable assurance that there is sufficient demand for that facility or equipment. Even in these circumstances, any benefits must be structured so that they would not prevent a consultant from referring a patient to a different facility where it would be in the patient's clinical best interests to do so.

23. Spire would also suggest that the CC consider whether the fee caps imposed on consultants, and the special contracts imposed on new consultants by some PMIs, may amount to a barrier to entry for consultants.

24. GPs should never be incentivised, directly or indirectly, by PHPs, PMIs or consultants for referrals.

Provision of information about Private Healthcare Providers and Consultants

25. The route to private healthcare treatment for both PMI and self-pay patients is usually through health professionals (usually the GP, sometimes the consultant). GPs are the community gatekeepers: they know the patients, act in their best interests and will be aware of consultant outcomes in terms of patient experience. The patient may understandably be the least well informed from an educational point of view about his or her ailment and the appropriate treatment. This obviously cannot be remedied.

26. However, there are two areas where the patient's interests in dealing with healthcare professionals can be better safeguarded:

- (a) availability of quality and price information on PHPs and consultants; and
- (b) ensuring that healthcare professionals have no actual or perceived conflict of interest in recommending a particular course of treatment and/or a particular facility for that treatment, so that such a recommendation is made purely on medical grounds.

27. In order to give patients the best available information at the point of deciding on facility, consultant or clinician (i.e., having the best-informed field of vision, in conjunction with advice from their GP, to decide on healthcare) and to ensure that patients have genuine choice at all decision points, patients (and their GPs) need both quality and price information from PHPs and from PMIs.

28. As Spire has previously explained, the currently available information on quality and costs of PHPs aims to facilitate competition at the point of facility selection. This could be enhanced. The larger PHPs are currently spending significant time, effort and expense on a project to make a considerable amount of information available to consultants, GPs and patients, and have made significant progress towards setting up such a system (the Hellenic Project, which is being renamed the Private Health Information Network or PHIN).

29. The industry-funded PHIN project will make significant cross-industry quality data on a wide variety of indicators available to patients, GPs and PMIs. While significant progress has been made in the collection and publication of information

about the quality of PH facilities, further progress could be made in this area and would be beneficial to patients. Work on this project has recently been accelerated.

30. Patients also face an information gap with respect to the cost of PH services versus the coverage provided by PMI policies. Spire believes that patients require additional clear and timely information from PMIs about:

- (a) the coverage provided by PMI policies;
- (b) coverage limits and the current status of the patient's expenditures against those limits; and
- (c) the likelihood and amount of any shortfall.

31. The provision of such information by PMIs would facilitate patient choice of the appropriate PHP and consultant, and the patient experience in terms of anticipation of the financial consequences of his or her choice.

32. With respect to consultants, the customer may be a combination of patient and advising/recommending GP. Either way, the key issue is the nature and extent of the information that consultants should provide, and how that information should be communicated and accessed. More accessible and usable quality and cost information would support patients' reaching informed financial decisions.

33. As suggested by the OFT, the Royal Colleges and/or GMC are well-placed to manage the process of providing additional information about consultants. These specialist bodies are already charged with monitoring and regulating consultant performance, collecting relevant information in the shape of consultant accreditation exercises, and have the expertise required to produce credible and useful assessments.

Vertical effects

34. The CC should consider whether vertical integration in the private healthcare sector results in either customer foreclosure or input foreclosure.

1. INTRODUCTION

1.1 This submission by Spire responds to the Issues Statement published by the CC on 22 June 2012.

1.2 The submission is structured as follows:

- (a) **Section 2** summarises the history of Spire and its approach to patient care. These matters, including a description of Spire's expansion and investment programme, are more fully described in **Appendices A, B and C**;
- (b) **Section 3** provides an overview of the UK healthcare market and identifies the key themes relevant to sector competition. These are more fully described in **Appendices D and E**;
- (c) **Section 4** sets out Spire's position on each of the individual Theories of Harm developed in the CC's Issues Statement; and
- (d) **Section 5** provides Spire's concluding remarks.

1.3 This submission is confidential, as it contains commercially sensitive information and business secrets, the publication or disclosure of which would significantly harm the legitimate business interests of Spire and its direct and indirect subsidiaries and affiliates.

2. SPIRE STRATEGY

2.1 Spire is a dedicated provider of quality private healthcare (**PH**) services in the UK healthcare market. The history and development of Spire is described in **Appendix A**.

2.2 Spire's mission is to be the best private provider of quality healthcare in the UK. Spire's success in the UK healthcare sector depends on offering patients the best quality of clinical care and patient service at competitive prices. Customer satisfaction is crucial to Spire's success, whether that be from patients, their GPs or the consultants who treat them in Spire facilities. Spire's strategy has therefore been to focus on delivering outstanding patient outcomes. Spire seeks to distinguish its proposition from that of the NHS and other PH providers (**PHPs**) by providing an individual and higher quality service to patients. Spire therefore focuses on investment in facilities, consultants, staff and infrastructure to provide superior quality, access and choice. To this end, Spire has improved the quality and efficiency of its general surgery and orthopaedics offerings, while at the same time developing and expanding its capabilities in areas of higher acuity such as cardiothoracic surgery, cancer treatments, neurosurgery and bariatric services. Spire also has focused on broadening its consultant base, in order to provide a wider range of choice and better options for patients.

- (a) [REDACTED].⁴

⁴ Including its acquisition of the Classics hospitals, London Fertility Centre and Spire Thames Valley Hospital.

2.3 Further details of Spire’s investment in its facilities and expansion are provided in **Appendix B**. Investment in the Spire estate is planned to continue. Details of Spire’s anticipated investment in its hospitals in the next financial year are included in **Appendix C**.

2.4 Spire hospitals adhere to a common governance framework and a common objective of clinical excellence. However, an important element of Spire’s strategy is also to ensure that hospital directors have local autonomy to drive decision-making and to engage with their local communities, so that they can tailor their hospital’s services accordingly.

3. PRIVATE HEALTHCARE IN THE UK

3.1 UK patients can choose from a wide range of available healthcare options at every step of the patient journey, they are faced with a highly competitive landscape and a range of choices. They can choose between:

- (a) competing insurers (to reimburse their medical costs);
- (b) NHS care (free at the point of delivery) or private healthcare provision (from either PHPs or PPUs);
- (c) different consultants; and
- (d) competing hospital providers.

3.2 At each critical step in this journey, patients can be steered by GPs, consultants or PMIs to use the NHS or rival PHPs. To secure its place in the patient’s field of vision at each decision point, Spire must therefore provide a patient with a more attractive offering than that represented by the NHS or its PH competitors.

3.3 Spire competes in a vibrant and dynamic marketplace for the provision of private healthcare. Participants are constantly evolving new and innovative services to capture a greater share of what has been, at best, a static level of demand. There is a wide variation in the ranges of treatments offered by different private hospitals, which is greatly influenced by the local NHS facilities. There are also marked changes in treatment specialisation and the prevalence of smaller facilities. PHPs cannot afford to stand still if they want to continue to differentiate themselves from the NHS and the increasing threat posed by NHS private patient units (*PPUs*).

3.4 There are a number of strong competitors for the provision of PH services in the UK. The largest provider is General Healthcare Group, with approximately 25% of UK acute beds for the provision of PH services. Other significant competitors to Spire include Nuffield Health (13%), the NHS private provision (11%), Ramsay Healthcare (9%) and HCA (7%). There are also a number of smaller operators with less than 5%, including the London Clinic, St John & Elizabeth, Aspen, Benenden and HMT. Furthermore, Spire faces significant competition from limited or single service line providers such as the Bridgewater Hospital, the Birmingham Clinic, the Horder Centre, etc. These are providers that generally focus on one basic service for which they aim to achieve high volume with a low price.

3.5 In addition to alternative PH providers, the NHS constitutes a significant constraint on Spire's business. Indeed, PH spend constitutes a very small percentage of the overall provision of healthcare in the UK. The rest is made up by the NHS, which is a provider of the same basic service, but importantly at no charge to the patient. The self-pay patient must therefore make a choice between a free service provided by the NHS or a paid service provided by a PH provider. The company or individual covered by PMI essentially makes the same choice when deciding to opt for insurance.

3.6 Even once an individual is covered by insurance PH providers are still competing with the NHS:

- (a) the NHS is always a free alternative to the PH services offered by Spire;
- (b) insurance may not cover the full cost of treatment, leading patients to use the NHS to avoid a shortfall. In addition, patients may be reluctant to use up part of their coverage where their policy includes a maximum reimbursement level;
- (c) PMIs encourage their members to use free NHS services rather than to claim under their policies for the services of PH providers;
- (d) insured patients are often unaware that they are insured for PH provision and GPs do not systematically ask patients when considering making a referral. Insured patients therefore often end up using NHS services by default; and
- (e) NHS PPUs compete directly for private patients. These PPUs have operational and financial advantages over other PH providers.

3.7 As the CC notes⁵, the interactions between the NHS and the private sector are numerous and varied. One area not mentioned in the Issues Statement is that entry by a patient into the private healthcare pathway is usually determined by an NHS employee/contractor – the GP. NHS conduct influences all aspects of private healthcare, from constraints put on consultants' availability to location of and treatment provided by NHS hospitals. It is obvious to Spire (and no doubt all the PHPs), and evidenced by countless internal management reports, that there is also a direct relationship between the national, regional or local strength of the NHS from time to time, and the numbers of patients seeking private healthcare.

3.8 Further detail on the overall structure of private healthcare provision in the UK is provided in **Appendix D**. **Appendix E** explains the various patient pathways into a Spire facility.

4. SPIRE COMMENTS ON THE CC'S THEORIES OF HARM

I. MARKET POWER OF HOSPITAL OPERATORS IN LOCAL MARKETS

4.1 Spire understands that the CC plans to examine whether hospital operators may have market power with respect to patients in particular geographic areas. As suggested

⁵ Issues Statement, paragraph 14.

by the CC, even if the market for PH provision were highly concentrated, that level of concentration would only adversely affect competition if it resulted in reduced innovation, limited availability of treatment, increased cost, or reduced value and quality of available PH.

4.2 Even in areas where there appears to be only one private hospital, there is significant competition from:⁶

- (a) PHPs (PHPs outside any given local area may advertise in the area, open satellite clinics in the area, or be potential entrants to the area);
- (b) The NHS (patients can access private care through the NHS, and can switch to publicly funded care through the NHS at most points in the patient pathway);
- (c) PPU (competition from PPU is expected to increase following the recent lifting of the NHS revenue cap); and
- (d) Increasing competition from “single line” and other alternative facilities (this is a growth area, increasingly recognised by PMIs).

4.3 This competition has resulted in a market characterised by innovation, increasing availability of treatment, and increasing value and quality of available private healthcare.

4.4 As noted by the CC in its Issues Statement, the definition of relevant geographic markets in private healthcare provision is complex and may vary both with the local environment and across specialties or types of treatment. The definition of the relevant geographic market must affect any assessment of local concentration.

4.5 For the avoidance of doubt, Spire sees no significant difference in the application of the arguments below to the PMI and the self-pay segment of private healthcare.

Private healthcare providers face extensive local competition

4.6 Private healthcare providers face competition both from the NHS and from other providers in the PH sector (including PPU and alternative suppliers such as out-patient clinics).

4.7 *PH providers are extending their reach into new geographic areas.* There is a growing trend for PH providers to establish satellite consulting rooms outside their traditional catchment areas. Such facilities aim to extend the reach of a hospital, and also facilitate access to a broader range of competing services for patients in the area of the

⁶ As described below in **Section 4(III)**, many of these conditions of competition are affected by PMI action. For instance, PMIs are able to alter referral patterns (through open referral programs), and encourage patients to use the NHS by offering cash incentives.

satellite facility.⁷ PH providers also frequently engage in advertising and other outreach efforts to reach patients in a broader geographic area.

4.8 ***The NHS is a significant competitor to private healthcare providers in all local areas.*** As noted above, PH provision in the UK cannot be considered in isolation from the NHS. There is extensive (and intensive) competitive interaction between the two.

- (a) Patients can and do choose between private and NHS care at a number of points in the patient pathway:
- (i) Initially, patients consider whether they may want access to private healthcare and make a financial risk management decision: they can either take the risk that they will need to obtain treatment and pay the full cost at the time of treatment, or take steps to offset that risk by purchasing insurance that will cover some or all of the cost of treatment;
 - (ii) At the point of seeking treatment, patients choose to access either NHS care free at the point of delivery, or private care which may be funded by a PMI, the patient themselves, or some combination of the two. Local NHS availability (and incentives from PMIs to use the NHS) may affect patient decisions at both these points; and
 - (iii) Patients may also switch between private and public care during the course of treatment. For example, a patient who knows that a private hospital participates in the NHS choose and book scheme may check the NHS waiting times and choose to access that private hospital (and, in fact, the same consultant) funded by the NHS. In that situation, the NHS is simultaneously acting as a competitor and a customer to the PHP. A patient who has elected to seek private treatment from a PH provider may switch to the NHS when they realise that they are running low on PMI coverage. Indeed, PMIs will sometimes advise policy holders that the NHS could be an alternative source of care, or even provide patients with financial incentives to seek treatment through the NHS.⁸ Finally, a patient initially admitted to the NHS (for example, through A&E) may subsequently decide to switch to a PH provider.
- (b) When a patient is choosing whether to seek private or NHS treatment, there are a range of factors that impact on that decision:

⁷ For example, BMI's Midlands Orthopaedic Practice has a satellite base in Sutton Coldfield, but surgery is conducted in Birmingham. Similarly, the Spire Methley Hospital in Leeds has set up a satellite clinic in Barnsley [X].

⁸ For example, Bupa offers a no claims discounts to members (see: www.bupa.co.uk/uk-products/excel/pid/14581) and offers a cash benefit for each night a customer who is eligible to claim in-patient cancer care on their Bupa policy receives in-patient treatment provided free by the NHS. A similar benefit is provided for out-patient, day-patient and home treatment for chemotherapy or a surgical operation where these are obtained free through the NHS.

- (i) Many patients with PMI elect to use the NHS for financial reasons including avoiding the loss of their no claims discount, avoiding erosion of fixed annual benefits (usually outpatient related), or in order to qualify for a cash payment;
 - (ii) GPs can, and do, direct PMI patients to the NHS, whether deliberately by recommending treatment in the NHS or by omission in failing to consider whether a patient has PMI;
 - (iii) NHS waiting times and perceptions of NHS quality have a significant effect on PH demand: where the quality of the service offered by the NHS is perceived by patients as more comparable to the quality of the service offered by PH providers, patients may see no reason to opt for (and pay for) private care; and
 - (iv) The location of the NHS is almost always equally convenient for patients seeking PH because consultants offering private treatment typically also work in a nearby NHS hospital.
- (c) Accordingly, in order to attract private patients, a PH provider must continuously seek to differentiate itself from the relevant NHS provision in the eyes of both patients and GPs. PH providers seek to do this in various ways:⁹
- (i) by surpassing the quality of the local NHS facilities (which is important both for attracting patients and for persuading consultants who will attract and recommend a hospital to patients);
 - (ii) offering a superior patient experience (including superior levels of customer service, private rooms, convenient car parking and flexible visiting times);
 - (iii) offering procedures that the local NHS does not (or will only offer reluctantly – such as procedures that are rationed by the NHS)¹⁰;
 - (iv) having a shorter waiting list;
 - (v) offering choice of appointment and operating time;
 - (vi) guaranteeing treatment by a consultant rather than a junior doctor; and
 - (vii) offering the consultant and procedure of the patient's choice (for example, a PH facility may invest in specialist cardiac equipment to allow it to begin offering more complex cardiac procedures. [X]).

⁹ See: www.spirehealthcare.com/Patient-Information/Why-go-private/.

¹⁰ For example, many NHS Trusts restrict access to procedures such as tonsillectomy for recurrent bacterial infections, haemorrhoidectomy, hernia repair, and cataract surgery for patients not meeting set standards of visual impairment.

4.9 ***PPUs represent a significant and growing competitive presence.*** Currently, the amount of income that NHS Trusts can generate from private patients is strictly limited. This private revenue cap, however, is being increased to 49%, significantly increasing the scope for Trusts to engage in private provision.

- (a) PPU (and other NHS private care) already represent the fourth largest provider of private acute healthcare in the UK. As the private revenue cap increases, this share is likely to grow.
- (b) NHS PPU have a unique position as private providers: their close connection to, and (generally) co-location with, NHS facilities provide them with access to established facilities, such as imaging suites, at marginal cost, and a lack of commercial risk since the NHS can easily switch facilities between public and private provision.
- (c) PPU have benefited from recognition by PMIs, at times to the exclusion of hospitals operated by other PH providers. For example, for several years, AXA PPP included the Frimley Park PPU in its network to the exclusion of the Classic (now Spire) hospital located nearby at Clare Park. Also, when Bupa de-listed a number of BMI hospitals in 2011, the schedule of proposed alternative competing hospitals that it sent to its customers included a large number of PPU.
- (d) It is also worth noting that the operation of NHS PPU provides new entrants to the UK with an opportunity to gain a foothold in the market [X].

4.10 ***Questions of concentration (and entry) must be understood against the background of a rapidly changing and dynamic UK healthcare sector.*** This Theory of Harm cannot be considered by the CC without an appreciation of the changing nature of the UK healthcare sector, and the impact of these changes locally. Patients can now elect to seek treatment either at traditional hospitals or from a wide range of different types of facilities:

- (a) Across all healthcare facilities, both private and NHS, there is an ongoing trend towards reduced in-patient treatment.¹¹ This has been driven primarily by clinical developments which have reduced the invasiveness of many procedures. Procedures that were previously performed on an in-patient basis can now be performed on an out-patient or day-patient basis, resulting in procedures moving out of hospitals to clinics or other out-patient facilities, opening up bed capacity in healthcare facilities. This has resulted in the emergence of new PH providers who may elect to provide relatively profitable high volume procedures without offering a comprehensive service or a comprehensive package to patients and insurers, but who have nonetheless secured PMI recognition.¹²

¹¹ See Laing & Buisson at p.145. The day case share of total day case and inpatient activity in the independent sector grew from 51% in 1997/8 to 63% in 2009.

¹² For example, Cobalt provides diagnostic screening services to patients in Gloucestershire, throughout the South-West and South Wales. See: www.cobalthhealth.co.uk.

- (b) In addition to the migration of certain procedures to other forms of healthcare facility, Spire has seen the migration of follow-on treatment to alternative facilities. For example, new consultant clinics have emerged, operating on a business model of providing follow-up outpatient support that was previously provided by hospitals.

4.11 These changes in the nature of PH supply have had a number of consequences for patients. For example:

- (a) Patients now have a wider range of facilities at which they can be treated, and can see the same consultant at multiple facilities given the prevalence of consultant split-practices.
- (b) As consultants have moved out of hospital facilities, they have been able to enter new catchment areas, develop new practices and expand patient choice of consultant.
- (c) PH providers have used both capacity and investment in their hospitals to develop new services, expand into new therapeutic areas, and increase the quality/range of services that they can offer to patients. For example, Spire hospitals have expanded into cardio-thoracic surgery, neurosurgery and bariatric services, and have invested in new intensive care and high-dependency units, which are necessary to undertake more complex procedures. These developments have increased patient choice, improved services and increased competition.

4.12 The flexibility of the above factors has been highlighted by:

- (a) consultants splitting their PH practices across multiple facilities,¹³ and
- (b) PMIs recognising a wide range of different PH providers in different areas, ranging from full-service hospitals to single line providers or specialists.

Geographic scope of private healthcare competition is complex

4.13 The CC has noted in its Issues Statement that geographic markets may vary with types of treatment and that there are multiple factors affecting the ability and willingness of patients to travel to different facilities. While Spire considers that dynamic local healthcare provision is driving competitive outcomes for patients, it would emphasise that geographic market definition is complex and requires a proper, locality by locality, analysis to understand how competition works in any particular area, as well as an understanding of how national dealings with PMIs impacts on any hypothetical local market power.

4.14 ***Thirty minute isochrones and areas from which 80% of patients are drawn are rules of thumb that may not provide an accurate measure of the geographic market.***

¹³ In a report prepared for the OFT, GHK found that more than half of consultants had contracts with, or admission rights at, more than one private facility (8% had admission rights at four or more private facilities), see: GHK, GP and Consultant Report, pp 47-48.

For some forms of treatment at some facilities, 30 minute drive time isochrones may account for approximately 80% of patients. However, on its own terms this is a conservative view of the distance over which hospitals compete, since a further 20% of patients travel further than 30 minutes and a higher percentage may travel farther in the event of an SSNIP. Moreover, there are many reasons why 30 minute drive time isochrones, or the 80% catchment area rule of thumb, may give rise to a geographic lens that provides a distorted impression of competition. For example, that simplistic lens would fail to reflect the following factors:

- (a) Catchment areas will vary with the availability and complexity of treatment, which in turn will depend significantly on the local NHS facility:
 - (i) A patient is less likely to want to travel a greater distance for a low cost less complex procedure or treatment (e.g. physiotherapy) and in any case this is likely to be more competitive locally because the barriers to entry (including capital expenditure) are lower;
 - (ii) On the other hand, a patient is more likely to be prepared to travel further for higher cost more complex surgery. Complex surgery is likely to be based in or near centres of excellence such as the NHS teaching hospitals. For similar reasons, catchment areas will tend to be larger for a hospital with more tertiary referral consultants;
- (b) As noted above, many PH providers are expanding their catchment areas by opening satellite clinics to attract patients to their facilities, further reducing the relevance of 30 minute isochrones;
- (c) Spire facilities regularly monitor competing facilities outside a 30 minute isochrone. [X]
- (d) PMIs direct patients to facilities outside the traditional 30 minute drive time; and
- (e) There are consultants at hospitals with limited local competitors who split their practice with other hospitals or facilities - suggesting that a thirty minute drive time would not capture these constraints.

4.15 ***The scope of healthcare competition has to be understood on a locality by locality basis.*** The preceding discussion highlights that any approach to local market definition should take into account factors in addition to drive times and post code blocks depending on local circumstances. These could include:

- (a) the proximity and reputation of the local NHS (including PPUs);
- (b) the location of referring GP practices;
- (c) the location of patients (they may have greater choice of PHP than would be suggested by drawing an isochrone around the PHP itself);
- (d) competition for consultants including how consultants may currently (or would be able to) split their practice between hospitals;

- (e) the local services (including satellite facilities) offered or potentially offered by other PH providers of all types including PPUs;
- (f) the ease with which an existing PHP could enter the local area, either through the use of a satellite facility or a fully fledged facility supported by local consultants and/or PMIs; and
- (g) topographical and cultural barriers to consultants and patients travelling to hospitals (including for example a rural area where hospitals are less prevalent).

4.16 ***Local conditions will affect the number of PH facilities that can viably operate in an area.*** The number of viable PH facilities in certain localities will depend on local conditions including population size, economic conditions and PMI penetration. For example:

- (a) PMI penetration varies significantly between areas. L&B reports that, in 2006 (the last year for which L&B reported this data), on a regional basis, PMI penetration in local populations varied from a high of 18.5% to a low of 5.5%. Since the majority of PH revenue is generated from PMI patients, PMI penetration will have a significant effect on the viability of a hospital;
- (b) Spire hospitals look at the ability of their local populations to support additional PH provision. [X] and
- (c) To the extent that there are facilities that face fewer local competitors, this situation may simply reflect recent entry and expansion by PHPs to serve new markets that had not been served before due to their low demand, i.e. a sign of an effective dynamic competitive process.

4.17 In some parts of the country, it may be possible to observe a single PH facility in a thirty minute isochrone centred on that facility. However, this does not necessarily imply that the owner of that hospital will benefit from market power since this situation can arise for various reasons:

- (a) In some regions, there is insufficient PH demand or PMI penetration to support multiple facilities within such a tight geographic area. For instance:
 - (i) Examples of hospitals in areas with one independent private hospital and with small PMI populations include: The Nuffield Hereford, BMI Carrick Glen, [X], and the BMI Fernbrae Hospital in Dundee. [X].;
 - (ii) [X] and
 - (iii) [X]
- (b) In other areas, a single facility may emerge as a result of consistently serving the needs of the market better than competitors (including, for example, superior clinical care, customer service and investment in the development of that facility), which is obviously an example of competition on the merits. This can also arise where a hospital has sought to expand the range of its services in a particular area

in order to serve new patients – and this has led to it being the only provider of a particular therapeutic service in that area.

- (c) In some local areas, a particular specialty may concentrate within a particular facility for efficiency reasons, e.g., the need to have sufficient volumes of patients to support an ICU.
- (d) Local competition cannot be understood without consideration of the wider context of PMI buyer power and the fact that negotiations with PMI are determined nationally (PMI buyer power is discussed further in **Section 4(III)**, below).
- (e) Based upon Spire’s own portfolio, hospitals in areas with fewer local competitors [X] do not suffer from a lack of investment compared to other hospitals, in respect of the markets which they serve. This is in line with the numerous local constraints facing PHPs.

4.18 ***Entry barriers into local markets are not insurmountable.***¹⁴ Whatever the reasons behind the emergence of a facility with limited local competitors, suppliers do not benefit from market power since market positions remain contestable. If the existing facility were to allow its standards to decline or to become less efficient, this would provide a realistic opportunity for entry by a competitor [X]. Since consultants prefer to operate at higher quality facilities that support higher quality service to patients, a new high quality entrant in such an area would be well-placed to attract consultants, be it a PHP-operated hospital or a PPU, provided it was recognised by PMIs.

4.19 ***Impact of spare capacity on competitive constraints.*** The CC has raised a question about the effect of capacity constraints in private healthcare provision. Spire does not believe that capacity constraints limit local competition in private healthcare. While there may from time to time be a few isolated cases of capacity constraints, [X]. Spire believes the position of other PHPs would be similar. Most, if not all, private hospitals provide some volume of NHS treatment – any theatres or beds that a private hospital is using to provide NHS treatment is capacity that could be switched to providing private care. Several factors lead to spare capacity in PH provision:

- (a) Private healthcare provision has peaks and troughs driven by consultant commitments to NHS work;
- (b) Excess bed capacity is primarily due to the ongoing increase in the proportion of patients who are treated on a day-case or out-patient, rather than in-patient, basis; and
- (c) Given private patient requirements for short waiting times, a private hospital will always be aiming for a small level of spare capacity in order to allow speedy access to treatment for private patients requiring such at short notice.

¹⁴ The lack of significant barriers to entry in the private healthcare industry is discussed further in **Section 4(IV)** below.

4.20 The existing spare capacity provides patients with opportunities to switch between PH providers and intensifies the existing competition in the market. It is also apparent that incumbent spare capacity in a local area does not create insurmountable barriers to entry, as is clearly demonstrated by Circle's entry strategy. Circle has built, or announced plans to build, facilities at a number of locations which are already heavily contested by PH providers with significant spare capacity already available in the local PH market. [X].

Fostering competition

4.21 To summarise Spire's views on this Theory of Harm:

- (a) Private healthcare providers face significant competition from a range of providers, even in areas where there may appear to be only one private hospital.
- (b) Defining geographic markets for private healthcare provision is complex given the variations in local areas that result from specific local factors, and from differences between facilities, treatments and specialties.
- (c) The effectiveness of existing competitive constraints, even on PH facilities that may have few local competitors, is illustrated by the competitive levels of price and quality delivered by these hospitals, and the ongoing investment in these facilities.

4.22 However, a key issue that could limit competition is the operation of restricted networks by PMIs. This issue is discussed further in **Section 4(III)** below.

II. MARKET POWER OF INDIVIDUAL CONSULTANTS AND/OR CONSULTANT GROUPS

4.23 The CC has raised questions regarding market power of consultants or consultant groups in certain local areas. It has questioned whether the prevalence of such groups may:

- (a) reduce price competition in local markets, leading either to a shortfall in patients' insurance or to higher insurance premiums; and increasing charges for self-pay patients; and
- (b) reduce the quality of service for both self-pay and insured patients.

4.24 Reduced price and quality competition amongst a group of service providers to the private healthcare sector would appear to act against patients' interests.

4.25 The CC has also noted that the OFT report discusses the joint setting of prices amongst anaesthetists. The CC states that it is not aware of the existence of joint price-setting arrangements among other consultant groups.

Spire view

4.26 Consultants in private practice are self-employed independent contractors with practising privileges at one or (often) more private healthcare facilities. A very large majority of consultants in private practice also work in the NHS.

4.27 As regards PMI-funded procedures, charges by consultants are a point of commercial interest between the individual consultant and the patient and are (in most cases) billed directly to the insurer by the consultant.

4.28 For self-pay patient procedures, Spire sends the patient an inclusive invoice which includes the costs of the surgeon and (if required) the anaesthetist.

4.29 As part of its investigation into this Theory of Harm, the CC should review whether the actions of consultants, either on their own or by forming into groups, are justified for one or all of the following reasons:

- (a) **Quality:** The CC will need to consider whether there are important quality benefits that accrue to the consumer (e.g. cover in the event of absence or emergency), which may outweigh any potential impact of consultant groupings on competition. There may also be an argument that such groupings are important to ensure that sufficient numbers of junior consultants continue to come into the private healthcare sector.
- (b) **Bargaining strength:** Consultant cooperative arrangements may serve to off-set the bargaining power of the PMIs. The bargaining power of PMIs could indirectly harm patients if it resulted in insufficient rewards to consultants, creating a barrier to consultant entry into the private healthcare sector. In this light, the CC may wish to investigate whether the fees established under the new PMI schedules (recently introduced at very short notice and apparently without consultation) provide an adequate level of compensation for the specialist services offered by anaesthetists and other consultants. Since most consultants, and particularly anaesthetists, are dependent on PMI patients for the majority of their income from PH, they are not well placed to reject the rates offered by an organisation controlling over 40% of PMI volumes.

4.30 As a PH provider, Spire's primary interest is in ensuring that it has proper clinical cover for the procedures carried out at its hospitals. The selection of an anaesthetist is a clinical decision, which traditionally has been left to consultants. It would appear self-evident that a patient's clinical benefit can only be enhanced by being operated on by a surgeon-anaesthetist team that has worked together previously (which is also usually how the NHS works). [X].

4.31 The CC has also contemplated whether reliance on established patterns of referral from GPs to consultants reinforces any consultant market power by making it difficult to re-direct referrals to new consultants:

- (a) [X].¹⁵
- (b) Most GPs have long-term relationships with their patients and will see the patient not only at the time of referral, but also after treatment by a consultant, providing GPs with insight into the effectiveness of the consultants to whom they are referring patients.

¹⁵ [X].

- (c) Most GPs are also familiar with consultants through their NHS practice. A large majority of consultants in private practice also practice in a local NHS facility and the majority of healthcare in the UK is delivered through the NHS rather than through private providers. As such, GPs referring patients to consultants for private treatment often have experience referring patients to those same consultants for NHS treatment.

4.32 Spire and the consultants operating at its hospitals generally do not rely on entrenched relationships as a source of referrals, but rather continuously invest in the attraction of patients through offering high quality service.

Fostering competition

4.33 The interests of patients require a difficult balance to be struck:

- (a) On the one hand, there is a clear advantage in head-to-head price competition between providers of services, in this case consultants.
- (b) On the other hand, there is often a strong patient interest in in-depth cooperation between clinicians of the same specialty, for example, in order to provide continuous, integrated care by covering weekends and emergencies.

III. MARKET POWER OF HOSPITAL OPERATORS DURING NATIONAL NEGOTIATIONS WITH INSURERS

4.34 The CC Issues Statement raises three potential Theories of Harm with respect to negotiations between PMIs and PH providers:

- (a) If a PHP had market power, either as a result of having market power in particular local areas, or as a result of the strength of its national network, that PHP might be able to leverage that market power in its negotiations with insurers;
- (b) If an insurer has buyer power, it may be able to leverage this in its negotiations with PHPs through the threat of de-listing or through its ability to steer patients between hospitals; and
- (c) If an insurer has market power in the PMI market, lower prices that the PMI pays to PH providers may not be passed on fully to purchasers of insurance through lower premiums.

4.35 Each of these Theories of Harm warrants consideration since any could result in a decline in the quality, value, range, innovation and availability of private healthcare services for patients.

PH providers do not have local or national market power

4.36 As set out in **Section 4(I)** above, there is significant evidence to suggest that private healthcare facilities face significant competition and that private healthcare providers do not benefit from local market power.

4.37 In the hypothetical scenario that PH providers did have market power through the ownership of facilities with limited local competitors, Spire and, it believes, other PH providers, could not leverage that market power, for the following reasons:

- (a) They would have insufficient aggregate negotiating power from the low proportion of each PMI's patients treated in such facilities to be able to achieve the outcomes claimed by the PMIs;
- (b) There could be no adverse effect of "forcing" a PMI to include all of a PHP's hospitals because agreements with PMIs guarantee no volumes to PH providers, and PMIs recognise multiple facilities. As a result, "forcing" the inclusion of one hospital is not the same as requiring exclusion of another PHP's hospital; and
- (c) Both PMIs and patients retain the unfettered ability to select either NHS hospitals or other PH hospitals. In fact, PMIs provide patients with incentives to select NHS treatment rather than claim on their insurance.

4.38 [REDACTED].

4.39 With respect to the possibility that its national network of hospitals provides it with market power, Spire notes that:

- (a) Insurers typically sell coverage to patients seeking coverage primarily in their own regions;
- (b) Spire's network of hospitals does not in fact provide national coverage;
- (c) Some corporates with nationwide workforces, such as HSBC, are comfortable with policies without national coverage;
- (d) Some PMI policies successfully provide national coverage while excluding a large number of PH facilities from their networks; and
- (e) There are several competing PH providers with similar alternative networks.

PMIs exercise significant power in negotiations with PH providers

4.40 The PMI providers are large, national (and often multinational) insurance companies, with considerable available resources. Most private healthcare patients seek coverage for their healthcare costs from a PMI company and the PMIs seek to leverage the volume of demand that they capture to negotiate better prices and reduce their reimbursement costs.

4.41 As noted in **Appendix D**, and also in the Issues Statement, the PMI market is highly concentrated on the buyer side. The four main PMI companies comprise over 85% of the market, with just two of these accounting for 66% of the market. Health insurance

claims reimbursed by insurers represent the majority of the revenues of most private healthcare providers.¹⁶

4.42 [REDACTED].

4.43 The strength of PMI bargaining power versus the PH providers is evidenced in a number of ways:

- (a) PMIs have shown that they will de-list PH hospitals from their networks (as they [REDACTED] have done to BMI and Nuffield). The PMIs have also been ready to engage in partial delisting of a major PHP's network – suggesting that “one in, all in” is not a policy that PHPs can credibly force on PMIs. The ability of a PMI to de-list does not appear to have been constrained by whether a private hospital faces limited local private competitors.
- (b) As noted above, PMIs are also able to steer patients away from private healthcare through several types of positive and negative incentives, for example:
 - (i) PMIs routinely advise patients to visit alternative facilities which will not result in shortfalls and offer cash incentives to patients not to claim on their insurance, but to use the NHS or other options instead; and
 - (ii) PMIs warn on the use of non-fee assured consultants, forbid top-up fees, and even impose direct restrictions on use of certain hospitals.
- (c) PMIs require additional “pre-authorisation” for certain procedures, such as certain arthroscopy procedures.
- (d) PMIs can, and do, themselves facilitate entry and expansion into the PH sector. For example, Bupa has supported the development of alternative provision of healthcare through:
 - (i) Its support for the development of the Healthcare at Home solution; and
 - (ii) Its Any Willing Provider program, which is an effort to create a market in specific service lines, such as MRIs, cataract surgery, or physiotherapy.

4.44 As noted by the CC, there is a risk that PMIs could leverage their power to exert too much pressure on the price paid to the hospital operator, leading to reduced investment by hospital operators in facilities and equipment. In a rapidly evolving field such as healthcare, ongoing investment in facilities and equipment is essential to ensuring the best outcomes for patients. Spire would encourage the CC to consider the effect of PMI power in the market for private healthcare.

¹⁶ There are PH providers, such as ISTC operators, who operate on a model of providing healthcare services to the NHS and who derive all or most of their revenues from the NHS.

National network agreements create efficiencies for PMIs as well as PHPs

4.45 National network agreements emerged over time in negotiations between PMIs and PHPs. The PMIs have sought national agreements and networks (including national pricing) from PHPs in order *inter alia* to:

- (a) reduce significantly the transaction costs for PMIs (and PH providers) when negotiating their agreements;
- (b) increase the consistency of price across PH facilities for PMI companies, thus simplifying and reducing administrative costs of the insurance and actuarial assessments needed by PMIs; and
- (c) obtain discounts from PH providers in return for membership of the network and the ability to access patients covered by the PMI's policies.

4.46 This desire for simplification and administrative efficiency explains why PMIs originally sought to negotiate standard prices for all procedures – moving away from ‘single line billing’ to package prices. [X].

4.47 However, the PMIs complained to the OFT about clauses in these agreements that allow for pricing changes if other hospitals are later recognised by the insurer. In fact, this is simply a fair *quid pro quo* since the original prices were agreed based on a restricted network which gave the PHP a better (though not guaranteed) chance to treat a larger proportion of the patients of that PMI. The PMIs can leverage the significant threat of exclusion of some, or all, of a PHP's hospitals from their network in negotiations with the PHPs.

If PMIs have market power in the PMI market, cost savings may not be fully passed on to patients

4.48 To the extent that PMIs have market power in the PMI market and fail to pass on cost savings to patients, this would reduce the accessibility of private healthcare for patients. Given the significant potential effect that such an outcome could have on patient welfare, Spire would encourage the CC to examine this possibility.

Fostering competition

4.49 Spire believes that the ideal outcome for patients and insurers would be for insurers properly to assume the role of reimbursing patients for the cost of healthcare (based on policy coverage), allowing patients to select care with full knowledge of:

- (a) the cost of care;
- (b) available reimbursement levels; and
- (c) the quality of care.

4.50 The greatest disadvantage of the restricted networks operated by PMIs is the consequential reduction in patient choice. Patients do not often know which PH facilities are included in PMI networks and indeed are unlikely to be able to assess the best facility

for their (future) medical needs at the time they are purchasing their PMI coverage. This is important, as it is unlikely a patient will change PMI to gain access to a PH hospital in case it is not listed, especially since existing medical conditions are difficult to reinsure. Spire agrees with the OFT that it is not necessary to have a restricted network of hospitals in order to gain the efficiencies of scale and scope claimed for them.

4.51 PMIs use networks (and “managed care”¹⁷) as a way to keep down costs. While Spire understands that PMIs wish to manage their costs, Spire considers that other approaches would be more suitable and achieve an equal, if not better, outcome for patients. In particular, to provide patients with the fullest range of choices, and to drive competition on the grounds of price and quality (which will be of most relevance to patients), Spire believes that the optimal situation would be to have automatic recognition by PMIs of all establishments:

- (a) which are registered with the CQC, HIW or SIH, respectively;
- (b) which carry out medical procedures or surgical procedures under anaesthesia in dedicated operating procedures (Acute PH Facilities); and
- (c) which meet minimum quality thresholds.

4.52 If all Acute PH Facilities were so recognised, PMIs could employ less distortive tools, such as permitting top-up fees, to ensure that patient decisions take account of price as well as quality considerations. PHPs would not be guaranteed patients and so would still need to compete to win them.

4.53 Such universal, non-exclusive recognition would:

- (a) maximise patient choice;
- (b) support investment by PH providers who would not face the risk of elimination of patient volumes through third party intervention;
- (c) allow PH providers to compete for patients on the basis of both quality and price; and
- (d) allow PMIs to assist patients in choosing between facilities.

4.54 Such universal, non-exclusive recognition would also eliminate one of the perceived barriers to entry to the sector (Theory of Harm 5), viz. the recognition of a new facility by the PMIs.

4.55 The availability of quality data from PHIN and provision of more transparent pricing data, particularly for PMI patients, will help facilitate even greater competition for patients and support guidance by PMIs.

¹⁷ See **Appendix E** for a description of how managed care programmes work.

IV. BUYER POWER OF INSURERS IN RESPECT OF INDIVIDUAL CONSULTANTS

4.56 The CC has suggested that it is possible that insurer caps on consultant reimbursement fees may:

- (a) suppress consultant fees below the competitive level, leading to a reduction in the quality of services provided by consultants to patients and affecting the incentives to innovate;
- (b) create distortions in competition between consultants when they are set for some consultants and not for others; and
- (c) result in a shortage of consultants willing to practice in the private sector and a reduction in the potential output of the sector.

4.57 To the extent that fee caps for consultants reduce innovation and supply, and distort competition, such caps are likely to reduce the value, quality, range and innovation in healthcare services available to patients.

Spire view

4.58 Spire's comments in this section should be read in conjunction with those set out in **Section 4(II)**.

4.59 PMIs have both potential and actual market power over consultants:

- (a) they have the ability to de-recognise consultants altogether, or to decide not to make certain consultants' services available to members covered by specific insurance products. In some instances, PMIs have de-recognised (or refused to recognise) consultants who charge above (or will not commit to) their prescribed rates;
- (b) some PMIs have changed their policy terms to guide the flow of patients towards cheaper consultants; and
- (c) some PMIs have recently set price caps which may prevent patients from being treated by more senior and/or preferred and/or more experienced and/or more specialised consultants; this has been done unilaterally in relation to a number of specialties and consultants.

4.60 Spire recognises that consultants face significant and rising costs when engaging in private practice. One important cost is practice insurance (adequate practice insurance is an important safeguard for patients), and insurance premia for many consultants have been rising significantly over recent years. Spire believes that it would be useful for the CC to review whether the consultant fees established under the PMI schedules provide an adequate level of compensation for the specialist services offered by consultants.

4.61 As a PH provider, Spire is concerned that the new contracts that certain PMIs are imposing on new consultants are resulting in fewer new consultants entering private practice and will ultimately reduce the choice and availability of consultants for patients.

Fostering competition

4.62 Spire believes that the interests of patients require that patients have the ability to select among the broadest possible range of consultants and benefit from competition between consultants for private patients. For PMI patients, this choice may be limited because many PMIs do not permit the patient to pay a top-up fee for treatment (including consultants' fees) in circumstances where the patient would be willing to pay extra to see their preferred consultant. Indeed, the purpose of the provision of extra information concerning consultants and PH facilities, which is envisaged under Theory of Harm 6, will be significantly reduced in effect if PMI patients are not given this opportunity.

4.63 Spire considers that obliging the PMIs to permit the use of top-up fees would be a less distortive mechanism for PMIs to manage their costs: top-up fees allow patients to decide whether to incur an additional cost to obtain the services of a particular consultant and promote price and quality competition between consultants.

V. BARRIERS TO ENTRY

4.64 The CC has questioned whether there are barriers to entry into private healthcare that are sufficiently high that the threat of entry is insufficient to deter attempts to exploit existing market power, in particular:

- (a) barriers resulting from national bargaining between PMIs and PHPs;
- (b) barriers resulting from the relationships between PHPs and consultants or GPs;
- (c) other barriers such as capital requirements and sunk costs; and
- (d) barriers to entry into the provision of consultant service in private practice.

Spire view

4.65 Spire considers that the primary requirements for successful entry into PH provision in a given area are:

- (a) sufficient local demand;
- (b) inclusion in reimbursement/coverage schemes by the major PMIs;
- (c) establishing a good reputation with local GPs and consultants;
- (d) availability of management expertise;
- (e) availability of high quality clinical staff; and
- (f) capital.

4.66 None of these requirements is insurmountable, as is evidenced by recent entry and expansion. Moreover, the entry requirements are much lower in the case of entry with satellite services or for a facility focussing on a narrow range of services.

(a) Barriers resulting from national bargaining between PMIs and PH providers

4.67 The CC Issues Statement suggests that, if PHPs have market power in some local areas, they may be able to leverage this market power to ensure that most or all of their hospitals are recognised by a PMI. The Issues Statement also suggests that a hospital operator may put pressure on insurers to continue to recognise all of the operator's hospitals and not to recognise the hospitals of new entrants.

- (a) As set out in **Section 4(III)** above, PHPs do not have local or national market power and cannot leverage market power in negotiations with PMIs.
- (b) In considering the recognition of hospitals by PMIs, it is important to note that the recognition of a hospital does not guarantee that hospital any volume of patients. Once a hospital has received recognition by an insurer, that hospital must compete to attract patients funded by the PMI.

4.68 As noted in **Section 4(III)** above, it is true that national bargaining has facilitated transactional efficiencies for both PMI and PH providers; but this does not in itself raise a barrier to entry. Further, Spire emphasises that “one in, all in” contracts in practice benefit PMIs and do not act as a barrier to entry, as they do not (at least in the case of Spire) prevent rival hospitals being recognised on PMI networks.

4.69 However, a related question is whether PMI-led restricted networks, negotiated nationally, act as a barrier to entry. Restricted networks of hospitals were, of course, developed to maximise PMI buying power by aggregating purchases and using them to achieve a better bargain across all hospitals on the network for treatment of that PMI's insured patients. In this respect:

- (a) as explained in **Section 4(III)** above, Spire believes that the PH sector would work best if all PH facilities were recognised by all PMI companies, and were therefore able to compete for patients on the basis of quality and price; and
- (b) as such, Spire does not support the development of restricted hospital networks, which necessarily limit patient choice and serve to exclude new entrants. Spire believes that efficient market outcomes will flow by allowing hospitals to compete properly for business.

(b) Barriers resulting from the relationships between hospital operators, consultants or GPs

4.70 The OFT suggested that existing PH providers may offer consultants incentives which could serve to raise barriers to new PH provider entrants. Spire believes that a more nuanced approach to consultant agreements is needed:

- (a) The most important consideration is that it is never appropriate for consultants to fetter themselves in a manner that does not align with the best interests or choices of their patients, or for PH providers to attempt to incentivise consultants to do so. The clinical interests of the patient must be paramount.

- (b) There are some types of agreements with consultants that are plainly pro-competitive and beneficial to patients. For example, an agreement whereby a PH provider commits to funding the development of a new facility or item of medical equipment, and consultants (in order to support the viability of the investment) commit to treating a particular volume of patients at that facility or using that item of equipment, encourages the development of new facilities and therefore increases the choices available to patients. In these circumstances, however, agreements with consultants negotiating treatment or referrals should always include a clear exception where it would be in the clinical interests of the patient to be treated at a different facility or using different equipment.
- (c) PH providers need to balance patient needs with the requirements for getting a business off the ground. Spire would suggest that the CC should only intervene where incentives are particularly excessive since in some cases apparent incentives may be important for delivering new services to patients.
- (d) However, some forms of consultant agreements are likely to distort competition, and are hard to justify on the grounds of either beneficial effects for patients or beneficial effects on competition, in particular where they are not associated with the need to recover substantial investments in new facilities or procedures. For example:
 - (i) Bonus payment incentive schemes contingent upon a volume target being met; and
 - (ii) Loyalty payments rewarding consultants for treating a higher proportion of their patients at a specific facility.

4.71 For similar reasons to those set out above, Spire believes that no GP should be incentivised for making referrals to specific hospitals:

- (a) Spire would distinguish educational and relationship building efforts with GPs from incentives provided to GPs. [X].
- (b) A GP should always advise and refer a patient based entirely on the clinical best interests of the patient. The decision as to how best to treat a patient should never be impacted by financial interest.
- (c) **Other barriers to entry into the provision of privately-funded healthcare services**

4.72 Spire's view is that:

- (a) Certain factors internal and external to the market – and mainly outside the control of the PH providers – condition the circumstances of de novo entry; but
- (b) Despite that, and reflecting the rapidly changing nature of UK healthcare services, there has in fact been significant new entry and expansion into the private healthcare sector.

4.73 The factors outside the control of the PH providers which have conditioned the circumstances in which de novo entry may occur include:

- (a) **The strength of local NHS competition:**¹⁸ as discussed above, the quality of the service offered by the local NHS (including both waiting times and other measures such as infection levels) is a key determinant of demand for PMI coverage and PH provision.
- (b) **Local NHS availability:**¹⁹
 - (i) In addition to generating competition for patients, NHS facilities are the essential source of the skilled consultants that a PH facility requires to deliver acute PH services. While it may be possible to develop some lower acuity services, such as diagnostic imaging or certain cosmetic treatments, without a local NHS consultant pool, PH providers rely on consultants from a local NHS facility splitting their practice between the NHS facility and local PH facilities. The large majority of consultants (96% according to the OFT's survey) undertake a mixture of NHS and private work;
 - (ii) Unsurprisingly therefore:
 - (A) PH facilities typically open in proximity to NHS facilities that employ the consultants required to deliver the PH services, and that will provide an ongoing source of NHS work for those consultants; and
 - (B) PH facilities are unlikely to open in areas where there is a limited NHS presence because there are unlikely to be consultants in the area to provide services at the PH facility;
 - (iii) Availability of NHS consultants is also a factor in a specific PH hospital deciding which services to offer. If the local NHS does not offer, for instance, a cardio-thoracic service, then the local PH facilities will not be able to do so, even where they think that there may be latent patient demand for the service; and
 - (iv) If (as is quite common) the local NHS management does not permit consultants to undertake private work or limits the places where, or hours when, they can do so, this will have a significant and direct impact on both existing provision and operational capacity and the prospects for new entry.

¹⁸ In its 2011 report, Laing & Buisson explains that private medical cover “has a competing product, the NHS, though both products also have complementary characteristics, which suggests the relationship between private medical cover and NHS care is not wholly straightforward. (p. 186).

¹⁹ The 2011 L&B report states that: “[e]mpirical evidence confirms that NHS performance impacts on the volume of demand for private medical cover, and a 2004 study by the Office of National Statistics found that regional variation in waiting times has a strong influence on private medical insurance demand.” (p. 186).

- (c) **PMI penetration:** Since most PH facilities derive the majority of their revenues from PMI-funded patients, the local population of such patients is critically important to the viability of a PH facility. In fact, PMI penetration levels vary significantly across the UK and some areas may lack a sufficient volume of existing or potential PH patients to support multiple, or even any, PH facilities.
- (d) **Local economic conditions:** Local economic conditions are naturally a significant consideration on entry. In areas of depressed economic conditions (exacerbated recently), there will be limited self-pay volume. Reduced local employment will understandably impact adversely on both corporate and self-funded PMI cover.
- (e) **PMIs setting conditions for successful entry:** PMIs have significant power to dictate the terms on which they will recognise a new hospital[~~✗~~].
- (f) **The cost of new facility construction:** Construction of a new full-service hospital requires significant investment (although there are several recent examples of the development of such hospitals including Circle Bath, Spire Shawfair and Brighton).

4.74 Despite the considerations set out above, there have been numerous instances of entry and expansion in private healthcare over the past several years. Moreover, these various examples have relied on different business models for entry – thus, it cannot be said that entry or expansion only happens under certain limited conditions or that such entry or expansion faces overwhelming obstacles. For example:

- (a) Circle, Vale and Nucleus have entered the market with new PH facilities, and indeed Circle has just announced a successful round of further fundraising.
- (b) Existing PH providers have:
 - (i) set up satellite facilities (Spire alone has 23 of these, including the satellite facility for its Thames Valley hospital in Windsor[~~✗~~]);
 - (ii) expanded the services available at many of their hospitals (see **Appendix B** for examples of that expansion at Spire hospitals);
 - (iii) expanded the facilities and capacity at many of their hospitals (see also **Appendix B** for examples of that expansion at Spire hospitals); and
 - (iv) built new hospitals.
- (c) The NHS has expanded significantly into private healthcare provision with the development of PPUs, which is set to increase considerably with the passage of the Health & Social Care Act 2012. The relationship between PPUs and NHS hospitals, and the fact that they are located either in the same building or in close proximity to each other, bolsters the potential strength of PPUs in that they benefit from access to existing facilities and infrastructure, and the ability of the NHS to facilitate consultant attendance at both the private and public facilities.
- (d) There has been very significant growth in consultant clinics, which are offering outpatient services previously provided by hospitals. Additionally, as described

above, the emergence of alternative facilities (single-line clinics, etc.) has reduced the costs of entry to new local areas by competing providers.

- (e) Home healthcare is also a significant and growing part of the market with home providers providing services such as cancer therapy, and management of conditions such as angina, diabetes and hypertension.
- (f) Some of the new entry or expansion has been supported by the PMIs themselves.
- (g) Some new entry has also occurred in stages. As noted above, and set out in **Section 4(I)**, there is a growing trend of providers entering new markets with alternative facilities such as day case centres, single line facilities and consulting rooms. Smaller facilities, once established in a market, may also expand into large-scale hospitals. For example:
 - (i) The Vale Hospital in Cardiff began in 2001 as a specialist medical outpatient facility operated from the leisure club premises within the Vale of Glamorgan hotel complex at Hensol.
 - (ii) In 2007, the founders of the Vale Clinic entered into a joint venture with Nuffield and formed Vale Healthcare.
 - (iii) In 2010, Vale Healthcare opened the Vale Hospital in Hensol, with 25 bedrooms and two operating theatres.

4.75 The very wide range of entry options, and the variety of business models on which such entry has been based, demonstrates two key realities:

- (a) Existing PHPs have needed to stay nimble and responsive to changes in local conditions of competition.
- (b) Suggestions of insurmountable barriers to entry to competition in the sector are overstated.
- (d) **Barriers to entry into the provision of consultant services in private practice**

4.76 The CC has suggested that consultants may have market power in certain areas, which may be connected to barriers to entry into the provision of consultant services in private hospitals. As noted in **Section 4(II)** above, there is often a strong patient interest in in-depth cooperation between clinicians of the same specialty, for example, in order to provide continuous, integrated care by covering weekends and emergencies. This interest must be balanced against the advantage of vigorous competition between providers.

4.77 In addition, as set out in **Section 4(IV)** above, Spire would suggest that the CC consider whether the fees established under the PMI schedules provide an adequate level of compensation for the specialist services offered by consultants. To the extent that PMI providers impose inadequate fee caps, and special contracts, on new consultants entering private practice, these arrangements may also amount to a barrier to entry.

Fostering competition

4.78 Notwithstanding Spire's view that significant new entry has taken place in the sector and that additional entry may have been discouraged by predominantly external factors, as set out above, Spire does believe that certain facets of the PH sector may in some circumstances make entry more difficult. As set out above, these are:

- (a) Restricted hospital networks;
- (b) Agreements between PMIs or PHPs and consultants where incentives are offered without a connection to a patient benefit; and
- (c) Agreements between PMIs or PHPs and GPs where incentives are offered to GPs to refer patients to particular facilities.

VI. AVAILABILITY OF INFORMATION REGARDING PRIVATE HEALTHCARE PROVIDERS AND CONSULTANTS

4.79 A patient seeking treatment must make two choices: (i) a choice of consultant; and (ii) a choice of hospital.²⁰ The primary concern of the patient, as guided by the GP, will be to obtain a referral to the most appropriate consultant and facility to treat them. It is then the consultant who primarily guides the patient as to where to be treated between the hospitals where he or she has practising privileges. Choice of consultant and choice of hospital may be connected where certain consultants only practice at one hospital, but different factors, which patients will assess either alone or with their GPs, will affect each of these choices. The level of additional information desired by patients may well vary depending on the type of treatment that the patient is receiving. A patient seeking relatively short-term treatment or routine diagnostics such as a CT scan is likely to have lower information requirements than a patient seeking longer term or more complex treatments, such as cancer care or surgery.

4.80 Patients make choices about the treatment options and healthcare providers at several points in the patient journey:

- (a) at the point of initial purchase (whether or not to buy private healthcare or PMI);
- (b) at the point of taking up care (whether to use the NHS or private treatment, and whether to pay for private treatment directly or through PMI);
- (c) when selecting a consultant or other clinical professional;
- (d) when selecting among PH providers; and
- (e) when selecting any additional service provider (for example, a physiotherapist following surgery).

²⁰ Patients, of course, must also make other intervening choices such as (i) whether to seek treatment; and (ii) whether to proceed with the course of treatment recommended by a consultant.

4.81 Depending on the particular decision at issue and the decision-point in the patient pathway, many pieces of information may be relevant to patients and their GPs when making healthcare decisions, including:

- (a) Information about options for treatment, and the availability of those treatment options;
- (b) Information about the cost and quality of the treatment offered by private healthcare providers (including factors such as waiting lists infection rates, patient satisfaction, service and reputation); and
- (c) Information about the cost and quality of consultants (including factors such as expertise, patient satisfaction, service and reputation); and
- (d) Information regarding the coverage provided by their PMI including any coverage limits and the likely amount of any shortfalls.

4.82 PMI providers are playing an increasingly significant role in influencing patient choices. PMIs direct patients to particular facilities and consultants both through the development of restricted networks and through direction provided to patients at the point of confirming coverage for treatment.

Spire view – information on PH provision

4.83 Regarding availability of information on PH quality:

- (a) Spire has recognised growing patient demand for information about treatment options and currently publishes key indicators of patient satisfaction and a range of clinical performance measures on its own website.²¹ [3<]. The published performance measures also include information on:
 - (i) MRSA blood infections;
 - (ii) clostridium difficile infections;
 - (iii) wound infections after hip and knee replacement surgery;
 - (iv) unplanned returns to theatre;
 - (v) unplanned re-admission to hospital;
 - (vi) health improvement for hip replacement, knee replacement, cataract surgery, hernia repair, gall bladder surgery and hysterectomy; and
 - (vii) patient satisfaction scores.

4.84 Spire believes that it has led the way on data publication in the PH industry in the UK. It has made effective use of its web-site and other channels of communication to

²¹ See: <http://www.spirehealthcare.com/Patient-Information/Our-Healthcare-Standards/>.

patients and their GP advisers to disseminate quality and performance information. Spire has also participated in reporting information on its NHS work to the NHS website. It publishes self pay pricing information.

4.85 Regarding the private initiative to collect and publish extensive and comparable information across the majority of PHPs (PHIN):

- (a) The OFT final report expressed concerns about the future effectiveness of PHIN as a voluntary industry initiative, and how information provision will be presented and monitored going forward.
- (b) Spire submits that the PH providers have demonstrated their commitment to PHIN through the investment of significant resources in the project. This project has recently been accelerated and a CEO for PHIN has been appointed.
- (c) In addition to supporting patient choice, PHIN will be a valuable marketing tool for the PH sector. The role of PHIN as a marketing tool will create an additional incentive for PH providers to support the project in the future.

4.86 Regarding availability of information on PH prices, the following table sets out key issues for self-pay and PMI cover patients.

Information requirements of PH patients in relation to PH costs

Type of Patient	Information requirements	Current situation
Self-pay	<ul style="list-style-type: none"> • Relevant information may be the “package price” (and what the package includes) that a PH facility will charge for the bespoke treatment needed by that specific patient. • For some self-pay patients, that may be a non-package price. 	<ul style="list-style-type: none"> • Spire currently requires that its hospitals provide quotations to all self-pay patients and believes that this approach should be the benchmark standard for information provision across the industry.
PMI cover	<ul style="list-style-type: none"> • Policy coverage: amounts of coverage, limits on coverage, exclusions, policy excesses, restrictions on hospital and consultant choice. 	<ul style="list-style-type: none"> • Patients frequently lack clarity regarding the coverage provided under their PMI policies because of the complexity of the policies, and less than transparent terms and language.
	<ul style="list-style-type: none"> • Outpatient coverage limits (many PMI policies set maxima for outpatient treatment costs in a calendar year). • Given the frequent shortfalls and the 	<ul style="list-style-type: none"> • Patients generally need to seek information and updates about their coverage limits, and current coverage availability. Patients may not be aware that they have exceeded their coverage limit for a considerable

Type of Patient	Information requirements	Current situation
	<p>increase in the number of services that are performed on an out-patient basis, patients require timely information and or reminders regarding these thresholds (and alerts when they have exceeded these thresholds).</p>	<p>period of time after incurring the excess.²²</p>
	<ul style="list-style-type: none"> • Magnitude of potential shortfalls. Patients require timely information not only about the possibility / risk of a shortfall, but also about the likely amount of any shortfall. 	<ul style="list-style-type: none"> • Patients often unaware of how shortfalls work or how they arise.

4.87 However, patients’ access to information on their PMI policy can on occasion be more problematic:

- (a) Many patients obtain their private healthcare coverage through their employers, resulting in the patients being a further step removed from their PMI providers and their policies. While the employer purchasing the PMI may be a sophisticated buyer, these patients also require timely information about the scope and availability of coverage since they will be responsible for any shortfalls, and have less choice about the scope of that coverage (they cannot for example switch PMI provider);
- (b) Whether patients receive private healthcare coverage through their employers, or purchase it independently, many patients lack sufficient information to assess the sufficiency of coverage for items such as outpatient expenditures; and
- (c) While the PH providers can provide some support to PMI patients in identifying potential costs associated with their treatment, they do not have full visibility of PMI policies for patients or agreements with consultants: this information must come from the PMIs. Nor do PH providers consistently have visibility on the scope of a given patient’s insurance cover, and so cannot advise on risk of shortfalls. In contrast, PMI companies have comprehensive information on costs of PH treatment they have agreed with PH providers, past shortfalls (or top-up payments) and patient policies that is not available to other participants in the private healthcare sector.

4.88 The development of stronger cross-industry price and quality data will be beneficial to the PH industry as a whole. Spire:

²² In the study it conducted for the OFT, Opinion Leader found that some study participants with coverage limits spoke about the difficulty of constantly calling their PMI to obtain their balance and expected their PMI to be more proactive in providing this information (p. 34). There was also some evidence of patient concern about not knowing whether they had sufficient cover to fund ongoing treatment (p. 38).

- (a) understands that the development of its business (i.e., attracting patients, whether PMI or self-pay) depends on communicating the quality, value and advantages of its services (both in comparison with the NHS and other PHPs) to prospective patients and their GPs (who will play an important role in communicating this information to their patients);
- (b) recognises that the provision of standard cross-industry quality data will provide a beneficial additional tool to support decision making by patients and GPs;
- (c) believes that, in addition to quality information, price information is important to support patient choices;
- (d) believes that the availability of more detailed PH facility data would enable PMIs further to advise patients on the quality of different facilities and directly link patient decisions to underlying costs; and
- (e) believes that the availability of more detailed PH facility data will provide consultants with an additional tool when selecting a facility either for their practice or for the treatment of a particular patient.

Spire view – information on consultants

4.89 It is likely that patients will need the assistance of expert advice (usually provided by their GP) to assess the information available to them, selecting the most appropriate consultant for a particular patient is rarely a question of data alone.

4.90 Much information is already publicly available on consultants:

- (a) Spire already makes information about its consultants available, on websites and via information provision to GPs and other health professionals. There is a growing trend for consultants also to develop their own websites, which are linked to Spire’s website; and
- (b) GPs refer patients to consultants for both NHS-funded and private treatment. As a result, GPs’ experience with consultants is often broader than their private practice. GPs obtain information on local consultants via local PCT and hospital information provision, professional training events, and other fora. This is an important aspect of information flow to understand because a high proportion of patient referrals for secondary care are made to the same consultants via the NHS.

4.91 That said, however, further information to support patient choice of consultant should be more widely available, including, in order that patients can make a holistically informed choice, having access to better information on price.

4.92 Increased availability of quality and price information regarding consultants will also enhance the existing ability of PMIs to direct patients among PH providers and consultants:

- (a) PMIs already use a variety of direct and indirect methods (such as warning a patient that a consultant is not “fee-assured” or otherwise bills at rates likely to precipitate a shortfall) in order to steer a patient to a PMI’s preferred

consultant/facility; the enhanced data would allow PMIs to use less blunt instruments, and place choice firmly in the hands of the patient;

- (b) These data would similarly support patients in exercising their ability to travel further to alternative PH facilities in order to access the services of a consultant who meets their price and quality requirements; and
- (c) Patients should also then (which is not always the case now) be able to understand the risks (and extent) of shortfall on their PMI coverage and assess the benefits of paying “top-up” fees to access their consultant of choice.

Fostering competition – information regarding private healthcare provision

4.93 The industry-funded PHIN project, will make significant cross-industry quality data available to patients, GPs and PMIs. In combination with more accessible information on costs for self-pay patients, PHIN will support greater patient choice and competition in PH. PHIN will provide patients with a tool similar to the NHS Choices website, which will support patient choices between PH facilities, and between a PH facility and the NHS. Information about Spire hospitals is currently provided on the NHS Choices website.

4.94 PHIN will measure, and publish data on, a variety of indicators including mortality, readmissions, returns to theatre, unplanned transfers, overnight admissions of day cases, MRSA, c. difficile infections, surgical site infections and PROMs. With further investment, PHIN plans to produce comparable data for all procedures on:

- (a) activity - total numbers of patients admitted for treatment and total number of procedures performed, available by procedure;
- (b) mortality - total number of in-hospital deaths and mortality rates by procedure (all in-hospital deaths within 30 days of the procedure);
- (c) length of stay - average length of time in-patients spend in hospital by procedure;
- (d) day case rates - % of patients who were not intended to stay in hospital overnight and did not stay in hospital overnight, available by procedure;
- (e) day case to inpatient conversion - % of patients who were not intended to stay in hospital overnight but converted to an inpatient stay, available by procedure;
- (f) readmission - % of patients admitted as an emergency within 28 days of discharge of a previous hospital admission, available by procedure;
- (g) transfers - % of patients transferred to another hospital for a higher level of care, available by procedure;
- (h) returns to theatre - % of patients returning to theatre for an unplanned procedure while they are still in hospital recovering from their initial procedure, available for a defined group of procedures;

- (i) infection control indicators – rates of surgical site infection following hip and knee replacement, MRSA bacteraemia and Clostridium Difficile infection, reported as per HPA definitions and available by procedure;
- (j) patient survey results – results of a list of core patient satisfaction questions agreed across the independent sector;
- (k) Patient Reported Outcomes – results of PROMS programmes operated across the independent sector; and
- (l) revision rates – 1 and 3 year revision rates following hip and knee replacement surgery.

4.95 The position of patients would also be enhanced by receiving from PMIs timely and detailed information about costs including:

- (a) Clear details regarding PMI policy coverage;
- (b) Clear and timely information about coverage limits; and
- (c) Clear and timely information about the cost of treatment to the patient (whether that be the full cost of treatment for a self-pay patient, or sufficient information about potential shortfalls to allow a patient to select a treatment option based on both quality and price for PMI cover patients).

Fostering competition – information regarding consultants

4.96 Consultants should be required to produce and publish quality and price data. However, the production of consultant data that will allow patients to make sensible price and quality comparisons is a complex matter. The production of risk adjusted and comparable quality information with a sample size that is possibly too small to draw distinctions which are statistically significant may not produce a meaningful result or the required improvement information. The patients would still also need to rely on their GP to interpret the data and it is possible that significant cost will be added just to confirm the current understanding of local GP's. The requirement to provide and publish data may also have the unforeseen consequences on the types of patients consultant choose to treat. A consultant providing more complex procedures, or treating higher risk patients, for instance, is likely to have a higher rate of complications and mortality. It is important that statistics not be produced in a way that could undermine patients' views of the quality of such consultants, leading to an incentive for consultants to avoid providing complex care or treating high risk patients.

4.97 Spire concurs with the OFT's suggestion that the Royal Colleges and/or the GMC are best placed to manage this process, since these specialist bodies are already charged with monitoring and regulating consultant performance, and have the expertise required to produce credible and useful assessments.

4.98 For example, the GMC currently receives information on consultant performance as part of consultant annual whole practice appraisals. In addition, the GMC is introducing revalidation for consultants in December 2012 and will collect extensive

information on consultant performance, through this re-validation process.²³ The GMC could potentially publish assessments of consultant performance based on the information that it gathers and assesses.

VII. VERTICAL EFFECTS

Importance to patients

4.99 The CC has raised a question as to whether the vertical integration of insurers is likely to lead to significant harm to competition. For example, Bupa currently owns the Cromwell hospital in London and Bupa Home Healthcare. Bupa is also developing out patient diagnostic and musculoskeletal services. Bupa (and possibly some of the other insurers) may also own some primary care facilities.

Spire view

4.100 The standard concerns with vertical integration are customer foreclosure and input foreclosure. In the case of customer foreclosure, the CC may consider whether Bupa would have the ability or the incentive to refuse to recognise hospitals located near the Cromwell on its network, and whether this would in turn reduce competitiveness of rival facilities by causing a significant loss in their patient volumes. The effect of such a refusal would be similar to the effect of a restricted network. In this context, Spire notes that Bupa is the largest of the PMIs with a share of 41% of private health insurance.

4.101 With respect to input foreclosure, the CC may consider whether Bupa would have the ability and incentive to refuse to treat patients insured by other PMIs at its facilities at the Cromwell and, if so, whether this would in turn reduce competitiveness of those PMIs because access to the Cromwell was crucial for those PMIs to reach policy holders located in or around London.

4.102 There are several factors that, in Spire's view, the CC will need to consider:

- (a) Analysis of either customer or input foreclosure requires careful analysis of relevant markets in order to begin assessing the competitive impact of that foreclosure. As noted elsewhere in this response, that is a complex exercise in private healthcare given the local nature of competition, the availability of different procedures at different hospitals and other aspects of the local environment such as the economy and PMI penetration.
- (b) Those local features are particularly relevant in London given the different transport links and the limited availability and high cost of land.
- (c) As Spire has noted elsewhere, there is no good reason to restrict a patient's access to any hospital. Spire's view is that patients should have full freedom of choice.
- (d) Vertical integration in itself is further evidence of PMIs' ability to exercise buyer power. That can take many forms and need not extend as far as full vertical

²³ See: <http://www.gmc-uk.org/doctors/licensing.asp>.

integration (as in Bupa's ownership of the Cromwell). It could just as easily encompass more favourable rates paid to new or expanding hospitals to "sponsor" entry or directing/steering of patients to a new facility. The Bupa Cromwell model provides another model for successful entry into private healthcare provision.

Fostering competition

4.103 Spire believes that vertical integration which involves an insurer owning a hospital facility is not automatically problematic, but may be so if it results in either customer foreclosure or input foreclosure. While Spire would encourage the CC to consider whether Bupa's ownership of the Cromwell does result in foreclosure, Spire does not currently have a definite view on this issue.

4.104 Spire does however have significant concerns about insurers and hospitals owning primary care facilities, as we believe this is tantamount to incentivisation of GPs to make referrals to particular consultants or facilities which, as we have noted elsewhere in this Submission, we believe should be barred absolutely.

5. CONCLUSIONS

5.1 In light of the comments above, Spire believes that the best outcome from the CC market investigation would be recommendations from the CC that support:

- (a) patient access to the broadest possible range of PH provision (facilities and consultants), with access not to be denied if the patient is himself/herself willing to pay all (self-pay) or part (PMI);
- (b) PHP competition for patients on the basis of quality, range, service, availability, and price; consultants competition for patients to be on a similar basis *pari passu*;
- (c) the provision of sufficient information to patients before the start of, and before each stage of, treatment to enable patients to give fully informed financial consent to the treatment; and
- (d) transparency for patients regarding any financial interest their consultant has in their place of treatment.

APPENDIX A:

SPIRE'S APPROACH TO PATIENT CARE

1. HISTORY OF SPIRE HEALTHCARE

A.1.1 Spire hospitals have been caring for patients in the UK for many years. Spire is a dedicated provider of quality private healthcare services. It is the second largest independent hospital provider in the UK, measured by revenues or by number of beds.²⁴ The hospitals in the Spire group were mostly built in the 1980s and have developed their reputation by serving their communities over the last 3 decades.

A.1.2 The Spire business began with the buyout of Bupa Hospitals in August 2007 by funds managed or advised by Cinven, followed by the acquisitions of the Classic Hospitals group in February 2008,²⁵ and the Gerrards Cross private hospital (now known as Spire Thames Valley Hospital) in March 2008. Over the past four years, Spire's hospitals have shown sustained growth in patient satisfaction, consultant satisfaction and clinical quality.²⁶

A.1.3 Other significant developments in the evolution of the Group include:

- (a) the construction of the Spire Shawfair Hospital in Edinburgh.
- (b) the acquisition of the London Fertility Centre in 2010;
- (c) the joint venture established with The Insight Network in 2010; and
- (d) the acquisition of Lifescan in 2011.

A.1.4 These developments have allowed Spire Healthcare to offer, respectively, greatly expanded day case, fertility, psychology and diagnostics services to patients.

A.1.5 Spire has also invested substantially in modernising, growing and expanding its business. These investments and expansion projects are explained in more detail below (para A1.9. onwards). However, it is important to understand first why Spire has chosen to pursue this strategy.

2. SPIRE'S APPROACH TO PATIENT CARE

A.2.1 No operator in the UK PH sector ever loses sight of the fact that patients have choices – among PMIs, doctors, and hospitals, and also between the NHS and PH.

²⁴ These numbers are based on revenues and beds for acute healthcare. The largest PH providers by revenue (in order of size) are: GHG, Spire, HCA, PPU, Nuffield and Ramsay. The largest PH providers by number of beds (in order of size) are: GHG, Spire, Nuffield, PPU, Ramsay and HCA.

²⁵ The Classic Hospitals portfolio had been part of Bupa Hospitals, but was sold to Legal and General Ventures in 2005.

²⁶ [X]

Patients will only choose to use PH where it offers a value and quality-competitive alternative to the NHS.

A.2.2 Overall, the success of the UK PH sector depends on offering patients the most appropriate possible choice at competitive prices. At heart, private healthcare is about choice – the choice of which consultant to see, which hospital to go to and when to be treated. As is explained in more detail below, some of the recent disagreements between PMIs and other UK healthcare participants (e.g., consultants, other clinical staff) stem from the perception that PMIs have sought to reduce or limit patient choice, rather than facilitate it.

A.2.3 [X]

A.2.4 The success of this patient-centred strategy has been demonstrated over the last five years. Spire hospitals are committed to delivering the highest quality of clinical care to patients. In Dr Foster's 2011 Hospital Guide, Spire was ranked as one of the best performing providers of hip operations and of knee operations out of all public and private providers in the UK.²⁷ Spire's hospitals have shown sustained growth in patient satisfaction, with 91% of patients rating their Spire hospital as excellent or very good in 2011. Spire has improved across a wide range of patient satisfaction measures including:

- (a) whether staff went out of their way to make a difference,
- (b) care and attention from nurses,
- (c) pain management,
- (d) cleanliness of the hospital,
- (e) how prepared patients were for being at home, and
- (f) the likelihood that patients would recommend the hospital.

3. INVESTING IN PATIENT CARE

A.3.1 Spire has invested heavily to achieve its strategic goals: both in modernising and updating facilities and equipment, and in developing and acquiring private healthcare capacity [X]. Indeed, Spire can provide a lengthy series of examples of service expansion and innovation – all aimed at improving its offering to patients (See Appendix B).

A.3.2 For example, Spire has significantly increased capacity in its facilities. Among various upgrades, Spire has invested:

- (a) [X];

²⁷ Dr Foster, 2011 Hospital Guide at p.35. The only operations for which the report lists the best performing providers are hip and knee operations.

- (b) in building a new hospital at Edinburgh Shawfair [X];
- (c) in Bushey, to upgrade existing diagnostic facilities [X];
- (d) in Windsor, to develop a satellite facility near the Princess Margaret hospital. [X];
- (e) in Southampton, [X] to add a fourth operating theatre, [X]; and
- (f) to develop in Bristol a new [X] extension (opened 2010) to meet the demands of patients. [X].

A.3.3 Spire has developed its oncology offering in order to resource and deliver more coordinated services to patients.

- (a) Through its joint venture with Cancer Partners UK (**CPUK**), it has significantly increased the options available to patients, particularly outside the London area. Prior to the joint venture between Spire and CPUK, there was no private radiotherapy option for patients outside of London. Spire teamed up with CPUK to add radiotherapy services to Spire's existing chemotherapy, CT and MRI scanning and cancer surgery facilities, thereby giving patients more choice and for the first time in the UK, outside of London, the ability to receive a complete oncology treatment from a single private hospital.
- (b) The Elstree Cancer centre in Hertfordshire is the UK's first standalone private cancer centre and offers chemotherapy treatment (provided by Spire) and radiotherapy (provided by CPUK).

A.3.4 Spire has significantly increased the diagnostics facilities available to patients across the UK. With a relatively underscanned population by international standards, an ageing population and more procedures requiring more complex scanning, UK patients, clinicians and insurers now consider fixed magnetic resonance imaging (**MRI**) and x-ray computed tomography (**CT**) scanning facilities to provide both a better quality diagnostic service (from a clinical perspective) and a better service in terms of patient care, comfort and convenience. In line with this development in patient need:

- (a) [X];
- (b) Spire acquired Lifescan UK, a specialist provider of CT scans, which now operates within [X] Spire hospitals across Great Britain, and from standalone facilities in Manchester and Guildford; and
- (c) Spire entered into a partnership with breast screening specialist BreastHealthUK to open screening clinics at [X] its hospitals.

A.3.5 One challenge facing PHPs is the lack of differentiation in PMI payments between static and mobile MRIs: static MRIs are more expensive to install and operate, but deliver a higher quality image and better patient service, yet they are reimbursed at the same rate as mobile MRIs.

A.3.6 Spire has also invested in expanding the availability of fertility services across the United Kingdom. For example:

- (a) Spire acquired an established fertility specialist (the London Fertility Centre), in Harley Street, London in March 2010. London Fertility Centre operates a hub and spoke model with clinicians and hospitals across the south of England; the acquisition created an opportunity for Spire to establish satellite fertility clinics in some of its 37 hospitals. [REDACTED]; and
- (b) Just prior to the London Fertility Centre acquisition, Spire launched IVF Scotland, a comprehensive fertility service at the new Spire Shawfair Park Hospital in Edinburgh.

A.3.7 Spire has increased ophthalmological services, opening dedicated eye centres at its Little Aston and South Bank hospitals and generally upgrading and investing in this service throughout its hospitals.

A.3.8 Spire has entered into partnerships with sporting entities such as St George's Park where Spire will offer sports science and physiotherapy services at the Perform facility.

A.3.9 Finally, Spire's initiatives have been undertaken with the objective of enhancing patient well-being. Similarly, during the recent PIP breast implant scandal, Spire demonstrated its commitment to patient safety by promptly offering every Spire patient with PIP implants a consultation with a consultant plastic surgeon and diagnostic imaging, as well as removal and replacement, if that was the patient's choice, all free of charge. Spire also went further than any other NHS or private provider by being the first to offer patients who chose not to remove their breast implants a further scan in two years' time, or sooner if they had any concerns. This approach is characteristic of Spire's core philosophy of pursuing patient care.

**APPENDIX B:
EXPANSION BY SPIRE**

[X]

APPENDIX C:
SPIRE PLANNED ESTATE INVESTMENT 2012-3

[X]

APPENDIX D:

OVERVIEW OF THE PRIVATE HEALTHCARE SECTOR

There are several groups that play a significant role in the provision of private healthcare: patients, the NHS, the PUs, the PHPs, consultants, GPs and the PMI companies. The role of each of these groups is elaborated below since it is important for the CC to understand the interactions among these groups.

1. PATIENTS

D.1.1 Any individual in the UK could potentially be a patient of either, or both, the NHS and PHPs in any given year. Patients may choose to seek private healthcare treatment for a variety of reasons including:

- (a) speed of service (and NHS waiting times);
- (b) the ability to select a consultant (with the knowledge that the patient will be treated by that consultant rather than by a member of their team);
- (c) infection rates in private and public hospitals;
- (d) the availability of private rooms;
- (e) procedure not being available on the NHS; and
- (f) “hotel levels” of service.

D.1.2 Patients who elect to seek private treatment may fund this treatment through PMI or pay for the treatment directly. Approximately 11% of the UK population has private health insurance.²⁸ Laing & Buisson (**L&B**) estimates that approximately 14% of independent medical/surgical hospital revenue in the UK is derived from self-paying British patients.²⁹ The volume of self-pay revenue has been increasing and L&B suggests that this increase appears to be, at least in part, the result of an increase in NHS waiting times.³⁰

D.1.3 The patient journey to reach a Spire facility is explained in more detail in **Appendix E**.

2. NHS

D.2.1 The National Health Service (**NHS**) was founded in 1948 with the objective of providing good healthcare to all. The founding principles of the NHS were to be

²⁸ L&B.

²⁹ L&B, p. 49.

³⁰ L&B, p. 49.

free at the point of use and available to all based on need. A proportion of healthcare remained private post-1948. As GHK notes in its report to the OFT:

The United Kingdom health sector is ... now a mixed market as both private and public markets are intrinsically linked. Private providers have contracts to treat NHS patients, with NHS funding of medical treatments provided via private healthcare more than doubling in the last four years... Furthermore, the role of private healthcare providers in delivering NHS services is set to increase and there is recognition of the private sector's potential capacity to deliver NHS targets...

Similarly, the NHS is also a direct supplier of private healthcare through NHS private patient units (PPUs). This role is also expected to increase as the White Paper proposed to remove the cap on the amount of finance FTs can raise through private healthcare...

The NHS still dominates the sector, employing about three-quarters of the workforce, with the private sector accounting for most of the remaining 25%.³¹

D.2.2 The NHS in England plays an important role in the marketplace as:

- (a) a purchaser of private healthcare;
- (b) a competitor to private healthcare providers (through both its public and private offerings): NHS performance is a key factor affecting demand for private acute healthcare, especially for self-pay patients;³² and
- (c) a supplier of consultants and other medical staff – the availability of consultants locally who can provide private healthcare services is generally determined by the local NHS provision.

D.2.3 As identified by GHK, the NHS remains by far the largest supplier of healthcare services in the UK. Laing & Buisson suggests that over 91% of elective surgery in 2011 was publicly funded.³³

D.2.4 The NHS has been undergoing significant reforms over the last several years, many of which are designed to increase patient choice. In its White Paper, *Equity and Excellence: Liberating the NHS*, the Government states that “[t]here should be a presumption that everyone should have choice and control over their

³¹ GHK, *Programme of Research Exploring Issues of Private Healthcare Among General Practitioners and Medical Consultants: Population Overview Report for the Office of Fair Trading*. (August 2011) at p. 9.

³² L&B, p. 107.

³³ L&B, p. 36.

care and treatment, and choice of any willing provider, wherever relevant.”³⁴ The paper points to a number of reasons why choice is important including:

- (a) **Public attitudes toward choice:** according to this paper, 95% of people feel that they should have choice over the hospital they attend and the kind of treatment they receive;³⁵
- (b) **Reasons people seek choice in healthcare:** people seek choice for a variety of reasons including accessing the type of healthcare that will give them the best chance of better health outcomes and accessing healthcare in a way that is most convenient for them and others;³⁶ and
- (c) **Improved patient outcomes:** the consultation paper, in fact, points to a review by the Sainsbury Centre for Mental Health and the King’s Fund, which found that choice had a central role in improving the daily experience of people with mental illness and supporting recovery.³⁷ A shared role in decision-making can also improve outcomes for people with long-term conditions.³⁸

D.2.5 The NHS is implementing its commitment to patient choice in a number of ways.³⁹ As of April 2009, NHS patients have the legal right to choose any hospital offering a suitable treatment that meets NHS standards and costs. The NHS points to evidence that shows that, if patients chose a hospital in which they feel comfortable and confident, they are likely to improve both the result of their treatment and their experience while in hospital.

D.2.6 The NHS has also undergone significant changes in the last decade with respect to its funding sources, facilities and service standards:

- (a) New financial approaches including stricter financial budgeting measures and practice-based commissioning have been introduced. In addition, NHS Trusts have been allowed to expand their private service offerings both within the

³⁴ Department of Health, *Liberating the NHS: Greater choice and control. A consultation on proposals* at 1.2, available online at: http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_120613.pdf.

³⁵ British Social Attitudes Survey, Natcen, <http://www.natcen.ac.uk/study/british-social-attitudes-25threport/findings> (2009).

³⁶ A. Dixon et al, *Patient choice - how patients choose and how providers respond*, Kings Fund, <http://www.kingsfund.org.uk/publications/> (2010).

³⁷ *Our Choices in Mental Health*, Care Services Improvement Partnership (2005).

³⁸ J. Hibbard, *Coaching To Patient Activation Levels Improves Disease Management Outcomes*, <http://www.medicalnewstoday.com/articles/153469.php>.

³⁹ Department of Health, *Liberating the NHS: Greater choice and control. A consultation on proposals* at para 2.11; http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/@dh/@en/documents/digitalasset/dh_120613.pdf.

NHS hospitals and in PPUs, increasing the significance of private care as a revenue stream for the NHS;

- (b) Many NHS hospitals have undergone refurbishment, which has often involved the introduction of upgraded amenities such as single patient bedrooms. Such amenities increase the relative attractiveness of the NHS hospitals. The government also adopted the private finance initiative, which has led to the development of privately financed NHS hospitals; and
- (c) The NHS has faced increasing pressure to meet patient service targets such as reduced waiting times. As NHS waiting times fall, demand for self-pay clinically necessary treatment at private facilities declines. In addition, the NHS books fewer patients into private facilities for direct local contract treatment.

3. PPUs

D.3.1 There are approximately 73 PPUs. In addition, a small volume of NHS beds are used for patients paying privately in other NHS hospitals.⁴⁰ Sixty-five of the NHS PPUs are managed in-house by the NHS and 8 are managed by independent hospital groups.⁴¹ As noted below, PPUs (and other NHS private care) represent the fourth largest provider of private acute healthcare in the UK. L&B estimated NHS private patient income at £445 million in 2010/2011, representing approximately 8% of the value of acute private care in the UK.

D.3.2 This proportion is also expected to grow substantially as the Health and Social Care Act 2012 increases the cap on private patient income that NHS facilities can make. That cap will now be set at 49%.

D.3.3 Care provided by PPUs generally covers the full range of the acute healthcare services provided by an NHS hospital. However, some PPUs specialise in particular areas such as cancer care, women's healthcare, or ophthalmics. These PPUs are often state of the art competitors in their field.

D.3.4 PPUs also enjoy the benefit of co-location with NHS hospitals. Such co-location can facilitate consultant participation in private care (a consultant can undertake private cases without travelling to a separate facility), provide access to high technology equipment (including imaging equipment), provide access to ITU and supports the delivery of high complexity treatment because complications can be addressed on site without the need to transfer patients to another hospital. Most importantly, the NHS is the main employer of the consultants that it seeks to engage to conduct private healthcare in PPUs.

⁴⁰ L&B, p. 54.

⁴¹ L&B, p. 84.

D.3.5 PMIs have shown themselves willing to include PPUs in their networks, including to the exclusion of hospitals operated by PH providers with other hospitals in that network.

- (a) For example, for several years, AXA PPP included the Frimley Park PPU in its network to the exclusion of the Classic (now Spire) hospital located nearby at Clare Park.

When Bupa de-listed a number of BMI hospitals in 2011, Bupa included a large number of PPUs in a schedule of alternative, competing hospitals that it was happy for its customers to use to replace the de-listed BMI facilities.

[REDACTED]

4. PRIVATE HEALTHCARE PROVIDERS

D.4.1 There are several types of providers delivering private healthcare services in the UK:

- (a) **Independent acute hospitals:** Spire views independent acute hospitals as facilities that include an operating theatre and provide care across multiple specialties for day and/or inpatients. L&B estimated that in mid-2011 there were 515 independent acute medical/surgical hospitals in the UK, of which 211 were registered to take inpatients and 304 were registered for day surgery only.⁴² Overnight bed capacity was 9,545 beds, an increase of 208 beds over the previous year. The increase resulted from expansion by both private hospitals and NHS facilities.
- (b) **Specialist clinics and providers:** Specialist clinics provide a broad range of services such as cosmetic surgery, bariatrics, eye surgery, fertility, pain management, cardiology, podiatric surgery, dermatology and gastroenterology.⁴³ This is an area where there has been significant recent entry. There are also several specialist providers of diagnostic imaging services in the UK including Alliance Medical (100 mobile and static MRI, CT and PET scanners), InHealth (diagnostic and imaging services, and cardiac services and nuclear medicine at 33 fixed sites, nearly 90 clinics and around 65 mobile units) and UME diagnostics (10 centres). These providers compete with hospitals offering in-house diagnostic imaging services.⁴⁴ The efficacy of some of the single line providers is evidenced by the fact that many have achieved PMI recognition.
- (c) **Clinician-led partnerships:** Clinician-led partnerships have opened a number of new facilities, including both hospitals and smaller specialist facilities. Significant examples include the Hand to Elbow Clinic in Bath, the

⁴² L&B, p. 58.

⁴³ L&B p. 74.

⁴⁴ L&B, p. 72-73.

Manchester ENT Clinic, the Nucleus Healthcare private gastroenterology day hospital in Newport South Wales, the Regent's Park Heart Clinic, the 3fivetwo group's Kingsbridge Private Hospital in Belfast, and the Edinburgh Clinic (which is now managed by Aspen).

- (d) **Home Healthcare:** Healthcare delivery continues to evolve and a growing number of services can be provided at home. One of the largest providers of home based care is Healthcare at Home, which is recognised by all UK PMI companies.⁴⁵ Bupa has also developed a proprietary home healthcare service: Bupa Home Healthcare. Home healthcare delivers a variety of services including oncology, and management of long-term conditions such as angina, diabetes and hypertension. For example, The Christie and Healthcare at Home worked to design a home treatment service for early-stage HER2-positive breast cancer patients with intravenous trastuzumab chemotherapy delivered to patients at home.⁴⁶
- (e) **NHS and PPU:** Private care in NHS hospitals and PPUs has been considered in detail above.

D.4.2 L&B reports that, in 2010, revenues for independent acute hospitals decreased by 0.6% in real terms.⁴⁷ According to L&B, these revenues were affected by a decline in PMI claims paid and tighter spending on acute mental health services by the NHS and other public sector organisations. (NHS work generates a significant proportion of revenue for many PH providers.)

D.4.3 Shares of the largest PHP providers are set-out in the table below.

Shares of PHP Providers⁴⁸

Provider	Revenue (£m)	Share of PH revenues	Number of beds	Share of PH beds
General Healthcare Group	£836	19%	2,643	25%
Spire Healthcare	£643	15%	1,642	15%
HCA	£490	11%	815	7%
NHS (PPUs and treatment delivered in NHS facilities)	£445	10%	1,123	11%
Nuffield Health	£392	9%	1,378	13%
Ramsay Healthcare UK	£350	8%	985	9%

⁴⁵ See: <http://www.hah.co.uk/for-patients-and-carers>.

⁴⁶ See: <http://www.hah.co.uk/sites/default/files/upload/files/2010%20Christie%20brochure.pdf>.

⁴⁷ L&B p. 37.

⁴⁸ Source: L&B.

Provider	Revenue (£m)	Share of PH revenues	Number of beds	Share of PH beds
Other Providers	£1,133	26%	2,082	20%
Total	£4,289	100%	10,668	100%

D.4.4 PHPs are regulated by the Care Quality Commission (*CQC*, which also regulates public providers) in England. Providers are required to meet essential standards under the *Health and Social Care Act 2008 (Regulated Activities Regulations 2010)* and the *Care Quality Commission (Registration) Regulations 2009*. Compliance is measured against regulations that focus on service quality and patient safety, relating to: care and welfare of patients, monitoring quality, safeguarding patients against abuse, cleanliness and control of infections, medicine management, safety and suitability of premises, safety, suitability and availability of equipment, respecting patient views, patient consent, complaints, records, staff suitability, staffing resources, staff support, cooperating with other providers, and information provision to enable decisions about care to be taken. Providers are also required to meet benchmarks relating to the fitness of the individual or entity providing the services, the fitness of managers, and the adequacy of training. Similar regimes exist in Scotland under HIS and Wales under HIW.

5. CONSULTANTS

D.5.1 Consultants are specialist doctors who provide secondary care to patients. In order to become a consultant, a doctor must complete all the necessary training for his or her specialty, and be accepted onto the specialist register for that specialty. Many consultants engage in both NHS and private practice. Estimates of the proportion of NHS Consultants who engage in private practice range between 55 and 59%.⁴⁹ L&B reports that fees paid to surgeons, anaesthetists and physicians for private specialist treatment in 2010 contracted by 4.3% in real terms from 2009.⁵⁰

D.5.2 Consultants are supervised and regulated by the General Medical Council (*GMC*), the independent regulator for doctors in the UK. The GMC controls entry to the medical register, and sets standards for medical schools and postgraduate education and training. Applicants to the GMC for registration must demonstrate that they are up to date and fit to practice.⁵¹

D.5.3 Consultants with practising privileges at Spire Hospitals are independent, self-employed contractors. Spire believes that consultants with practising

⁴⁹ BMA and National Audit Office estimates cited in L&B.

⁵⁰ L&B, p. 40.

⁵¹ http://www.gmc-uk.org/Specialist_Register_Scheme_for_Existing_Specialists.pdf_25404115.pdf.

privileges at other PH facilities are similarly engaged as independent, self-employed contractors.

D.5.4 Spire is strongly of the view that the person best placed to advise the patient about decisions that affect the clinical care of the patient is the consultant together with the GP. As such, consultants should advise the patient based on their clinical judgment. This does not mean that a patient should not make a judgment based on a balance of all factors (including cost), but it does mean that information about clinical outcomes has to be properly presented to the patient without being influenced by other considerations. In this connection, Spire is concerned that limitations imposed on consultant discretion by PH providers, PMI companies or others may compromise the care of the patient.⁵²

D.5.5 Consultants are required to have indemnity insurance or indemnity to cover risks to patients in their practice, and this is typically available from medical defence unions or from a smaller number of commercial insurance providers. PH providers (including PPU) generally establish requirements regarding levels of insurance coverage to be carried by consultants practising in their facilities.⁵³ Spire understands that consultants' premiums have increased significantly over the past few years. This increase may be connected with the anecdotal observation of an increase in the number of procedures carried out by less experienced surgeons. The transfer of volumes to less experienced surgeons may, in turn, be connected either directly or indirectly with open referral arrangements, and reduced fee arrangements stipulated by PMIs.

D.5.6 L&B suggests that Bupa has for many years been the *de facto* regulator of specialist fee rates by virtue of the fact that it sets specialist fee limits within its policies that are widely accepted as benchmarks by specialists and most other insurers.⁵⁴ Some groups have criticised the fact that the Bupa reimbursement levels have not risen as fast as general inflation, and in some cases has resulted in very substantial falls in reimbursement levels being imposed on consultants and patients without reasonable notice.⁵⁵

6. GENERAL PRACTITIONERS

D.6.1 GPs are the first point of contact for most patients and act as a gateway into secondary care. Their onward referral responsibilities give GPs a pivotal role in shaping the remainder of the healthcare system. Changes to the healthcare system

⁵² In a survey conducted for the OFT, GHK found that over a quarter of consultants noted an instance where a PMI provider would not allow them to treat patients at their preferred facility (GHK, *Programme of Research Exploring Issues of Private Healthcare Among General Practitioners and Medical Consultants: Survey Analysis Report for the Office of Fair Trading*. (August 2011) at p. 79).

⁵³ Coverage for consultants' NHS work is provided under the State Clinical Negligence Scheme.

⁵⁴ L&B, p. 92-93.

⁵⁵ L&B, p. 93.

in England mean that the GPs will have increased responsibility in the future, such as purchasing healthcare from secondary healthcare providers.

D.6.2 There are about 10,300 GP practices operating in Great Britain and about 40,000 GPs working within them, in addition to nurses, other health professionals, receptionists and so forth. Total expenditure on general practice for England is £8.3 billion. All must be compliant with CQC regulation.

D.6.3 Around 3% of all GP consultations by UK residents are privately funded and this figure has remained relatively static over at least the last 30 years. Private General Practice must compete at full price with a ‘free’ public sector alternative available to everyone within the UK. Because NHS GP services are generally regarded as adequate, the private GP market is much less developed than the private acute medical/surgical healthcare. Most patients therefore begin by seeing an NHS GP who will refer them to a consultant in either the NHS or a private facility.

7. PMI COMPANIES

D.7.1 There are four main insurance companies offering PMI in the UK: Bupa, AXA PPP, Aviva, and Pruhealth and a few smaller companies. Demand for PMI fell by 3.8% in 2010, reaching a total of 3,962,000 subscribers or 11.1% of the population.⁵⁶ The average price paid for private medical cover was estimated at £1,026 in 2010, increasing by 1.4% in real terms over the year.⁵⁷ Claims paid to private medical cover subscribers fell by 4.3% in real terms and, as such, gross margins for private medical cover providers increased from 20.5% to 21.6% in calendar year 2010.⁵⁸

D.7.2 The following table sets out the shares, by revenue, of PMI companies in the UK.

PMI Shares⁵⁹

Company	Revenues (2010, £m)	Share (%)
Bupa	1,493	41
AXA PP	918	25
Aviva	402	11
PruHealth (includes Standard Life Healthcare which was acquired in August 2010)	387	10.5
WPA	97	2.5
Simplyhealth	89	2.5
CIGNA	63	1.5

⁵⁶ L&B, p. 168.

⁵⁷ L&B, p. 169.

⁵⁸ L&B, p. 170.

⁵⁹ L&B, p. 206.

Exeter Friendly	41	1
CS Healthcare	23	0.5
Other Insurers	128	3.5
Total	3641	100

D.7.3 PMI companies have introduced a number of cost saving initiatives: many PMI companies, including Bupa, AXA PPP, Standard Life Healthcare and Simplyhealth, have introduced narrower hospital networks.⁶⁰ (Indeed, a number of these more restricted networks have excluded a number of so-called “solus” hospital sites.) Insurers typically offer financial incentives to patients to be treated by the NHS instead of privately (a perfectly legitimate practice).

D.7.4 In addition, PMIs have introduced initiatives such as:

- (a) ‘open referrals’, where GPs refer a patient on to secondary care without nominating a specific consultant. This generally allows PMIs to direct patients to particular consultants, based on their fee levels, who may not necessarily be the choice of the patient/GP;⁶¹
- (b) ‘managed care programs’, which allow PMIs to manage the end-to-end care pathway of a patient; and
- (c) ‘speciality networks’, which arise where PMIs have tendered for and created specialist groups of facilities to deliver a specific line of services (e.g. cataract surgery).

D.7.5 In summary, Spire would note that the balance between cost savings and patient choice is complex: L&B has suggested that it is “a rather odd paradox that insurers have increasingly focused on directing patients through networks at a time when successive governments have looked to facilitate choice for NHS patients.”⁶² This is a view to which Spire also subscribes – given that private healthcare is fundamentally about providing choice and access for patients, it is odd that PMI providers have been seeking to restrict patient choice. In Spire’s view, this is unlikely to increase the attractiveness of private healthcare to existing and potential customers.

D.7.6 PMI patients are typically the most significant source of revenue for PH providers. As such, PMI recognition plays an important role in the development of services.

⁶⁰ L&B, p. 89.

⁶¹ The open referral patient pathway is explained in more detail in **Appendix E**.

⁶² L&B, p. 89.

APPENDIX E:

PATIENT PATHWAYS

E.1.1 The typical patient pathway can be summarised as follows (each of these steps is discussed in more detail below):

- (a) GP consultation;
- (b) Referral to consultant;
- (c) Appointment with consultant; and
- (d) Surgery and follow-up.

E.1.2 Traditionally, a patient initially seeks treatment from a GP, who then, if necessary, refers the patient to a consultant. The majority of primary care is provided through the NHS, although patients can also seek treatment with a private GP. At the point of referral, the patient may opt to be referred to either the NHS or a private healthcare provider. There are many factors influencing this choice:

- (a) The availability of treatment: many NHS trusts are restricting access to certain procedures, sometimes referred to as procedures of “limited clinical effectiveness”, although patients and consultants would generally not characterise them as such. Affected procedures include hernia treatments, surgical treatment of varicose veins, surgical or laser treatment for a range of skin lesions (e.g. warts and cysts), tonsillectomy, adenoidectomy, surgery for sleep apnoea, cataracts, hernia repair, tests for confirming diagnosis of irritable bowel syndrome.⁶³
- (b) NHS performance: NHS waiting times remain one of the key factors driving patients to seek private healthcare. Other factors affecting patient decisions include infection rates at NHS facilities.⁶⁴
- (c) Initial site of admission: some patients may initially seek treatment at A&E. These patients do have the option of transferring to private care, but some may choose to remain in the NHS for the duration of their treatment.
- (d) The level of knowledge of GPs/patients about private healthcare.
- (e) Whether even those GPs who are informed about private healthcare offer private options to their patients. A survey conducted on behalf of Spire found that 40% of GPs surveyed stated that they would not ask patients if they even

⁶³ See, for example, <http://www.nottspct.nhs.uk/my-nhs-services/drugfunding/766-commissioning-policy-procedures-of-limited-clinical-value.html>.

⁶⁴ L&B, p. 107.

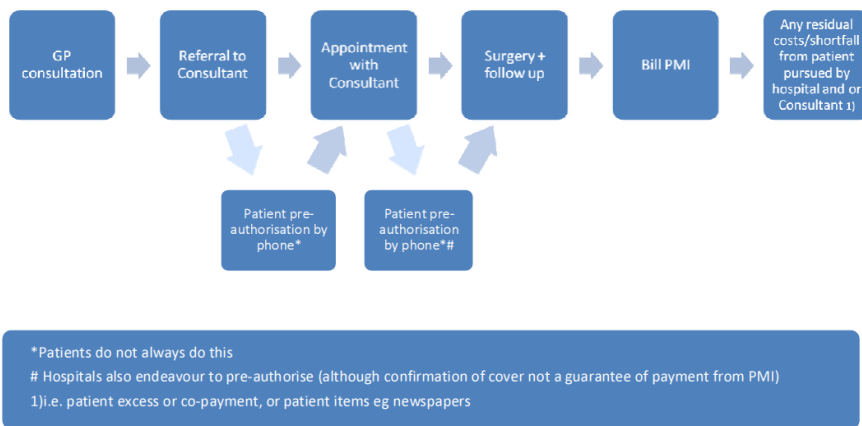
have private medical insurance.⁶⁵ A survey conducted by Opinion Leader for the OFT similarly found that many respondents commented that GPs did not always discuss private options proactively and that, in a minority of cases, GPs even showed resistance to patients going private and were seen to favour NHS treatment.⁶⁶

E.1.3 Spire distributes Consultant directories to all referring practices. These outline all Consultants practicing at a Spire hospital and their sub-specialty, as well as clinics available and contact details. Other information is distributed to GPs on an ad hoc basis, for example: guide price lists, new services and facilities, and education events held by the hospital.

E.1.4 Further information is also made available to GPs via Spire’s website and GP Connect. GP Connect provides information on Consultants, details of education events and contact details and allows GPs to refer online.

Pathway for PMI-funded patients

Traditional pathway-PMI



E.1.5 A patient will normally seek treatment initially from a GP, who then, if treatment is required, refers the patient to a consultant. In the majority of cases, a GP will refer a patient to a named consultant.

⁶⁵ GP Survey, October 2011.

⁶⁶ Opinion Leader, *The Patient Journey: Research to support the OFT’s private healthcare market study*. (August 2011) at p. 23.

E.1.6 A patient with PMI coverage seeking private treatment will typically need to seek authorisation from their PMI provider prior to their initial appointment with the consultant recommended by their GP (patients will sometimes fail to seek this authorisation). It is important to note that authorisation is a confirmation of cover and not a guarantee that the PMI will pay the costs of treatment.

E.1.7 Following an initial consultation with the consultant, the patient will typically need to contact their PMI provider again to seek authorisation for the recommended course of treatment.

E.1.8 At any point, the patient could elect to seek treatment through the NHS rather than a private provider.

E.1.9 Following treatment, the PH facility will issue its bill. PH providers will separate charges covered by PMI (such as operating theatre charges) from charges not covered by PMI (such as meals for guests) and issue separate bills to the PMI and the patient for these charges.

E.1.10 The PMI may identify additional items on its bill that it determines are not covered (e.g. excesses, amounts above annual fees, and consultant fees in excess of the amount the insurer will fund). Such charges revert to the hospital or consultant, which or who then needs to pursue payment from either the PMI or the patient.

E.1.11 In addition to the traditional PMI patient pathway set out above, several insurers have introduced new approaches in an effort to reduce re-imburement costs. On most of these pathways, rather than referring the patient to a named consultant, which would happen in the majority of other cases, the GP completes a patient referral form specifying the patient's presenting condition and the type of consultant (by specialty, but not by name) that the patient should see:

- (a) open referrals (used by Bupa): these differ from the traditional PMI patient pathway because the GP refers the patient to secondary care without nominating any specific consultant. The GP simply identifies the type of consultant specialty that is required. The patient then contacts Bupa, who will typically offer the patient a choice of 2 or 3 fee assured consultants (i.e. consultants committed to charging within Bupa fee limits). Bupa assigns these consultants a rating reflecting the match between the treatment required by the patient and factors such as the consultant's specialty, and the specific special interest of the consultant. The patient must then select one of the nominated consultants. Once the selected consultant has recommended a course of treatment, the patient will have to again seek authorisation from Bupa.
- (b) direct referrals: this is another type of referral where the GP will refer the patient to secondary care without nominating a specific consultant. After receiving a GP referral, the patient contacts his or her insurer, who provides the patient with a list of hospitals at which the patient may be able to seek treatment. The patient selects a hospital and the insurer then contacts the patient's preferred hospital to confirm the case details and the hospital's ability to treat the patient. The hospital must select a consultant who is committed to a known fee level and arrange an appointment for the patient: there is, of

course, no guarantee that the hospital will be able to source a consultant who will charge within the stipulated fee levels.

- (c) **fee-capped referrals:** this pathway has been introduced over the past year or two by some PMIs, including Bupa and AXA. Again, patients will typically start by seeking treatment from a GP who, in the majority of cases, will refer a patient to a named consultant. The patient then contacts his or her insurer to obtain pre-authorisation. The insurer may then inform the patient that the consultant recommended by the patient’s GP is known to charge fees higher than the insurer fee limit and that, therefore, all consultant fees may not be covered by the patient’s insurance. The PMI may suggest another consultant, who does charge within the PMI’s limits, to the patient. The PMI may also direct the patient to a third party, such as Alliance Surgical, who will source a fee-compliant consultant and get back in contact with the patient.

E.1.12 These alternative pathways represent cost containment attempts by insurers. Spire recognises the interest of insurers in limiting their costs, but is concerned that, in some instances, these pathways may unnecessarily fetter patient choice and access to the most suitable consultants or treatments. Spire also accepts the potential argument that such cost containment could also be in the interest of actual and prospective patients as a group, but would stress that this argument is only valid if the benefit of the reduced costs is clearly passed on to actual and prospective patients in the form of lower premia and/or improved policy coverage, and is not otherwise retained by the insurers.

Pathway for self-pay patients

Self Pay package price patient



*GP Consultation is not always required but in many cases patients consult their GP
 +Often multiple providers are contacted and patients compare price, facilities and surgeons before making their decision
 **Patients are explained what is and is not included in package price
 ^Patient pays for any miscellaneous items (items not included in package price, such as newspapers or visitor meals) post surgery

E.1.13 Most self-pay patients will make an initial appointment with their GP. The GP will, if treatment is required, refer the patient to a consultant or a hospital and, in the majority of cases, the referral will be to a named consultant. It is not,

however, always necessary for the patient to initially consult his or her GP (e.g. for cosmetic surgery procedures).

E.1.14 The patient contacts the hospital or the consultant's medical secretary to obtain a guide price for the procedure and to make an out-patient appointment. Patients often contact multiple providers, and compare prices, facilities and surgeons before making a decision.

E.1.15 The patient will then meet with the consultant for an initial consultation and the consultant will recommend a course of treatment for the patient.

E.1.16 Most self-pay patients are charged a package price for treatment. A small number of self-pay patients are charged on an itemised basis. Patients may end up on a non-package price pathway due to the health of the patient, the request of the consultant, or the complexity of the procedure.

E.1.17 At the point of initial consultation, the price of the procedure, and (for package prices) items that are included or excluded from the package price, are confirmed to the patient and the patient pays for the treatment. A patient paying on an itemised basis will pay a holding deposit, which is calculated based on the estimated price of the procedure, with adjustments for any significant expected deviations, such as a longer than usual stay in the hospital.

E.1.18 Following treatment, a patient paying a package price will be billed for any miscellaneous items not included in the package price, such as newspapers or visitor meals. A patient paying on an itemised basis will pay any outstanding amount on the bill, or be refunded for any excess. Patients are provided with a daily bill while in hospital to allow them to keep track of costs.

E.1.19 As with PMI patients, self-pay patients can, at any point, choose to switch to NHS.

APPENDIX F

DEFINED TERMS

<i>Acute PH Facilities</i>	Dedicated operating facilities for surgical procedures under anaesthesia
<i>AXA-PPP</i>	Private medical insurer
<i>BMI Healthcare</i>	Private healthcare provider
<i>BUPA International</i>	Private medical insurer
<i>CC</i>	Competition Commission
<i>CPUK</i>	Cancer Partners UK
<i>CQC</i>	Care Quality Commission regulating both PHPs and public care providers
<i>CT</i>	X-ray computed tomography
<i>ECN</i>	Extended choice network
<i>ENT</i>	Ear, Nose & Throat specialism
<i>ESWT</i>	Extracorporeal Shock Wave Therapy
<i>GHG</i>	General Healthcare Group, provider of private healthcare
<i>GHK</i>	ICF GHK, the brand name of GHK Holdings Limited is a multi-disciplinary consultancy firm
<i>GMC</i>	General Medical Counsel
<i>GP</i>	General Practitioner
<i>HALO</i>	Haemorrhoidal artery ligation operation
<i>HCA International Limited</i>	Private healthcare provider
<i>HDU</i>	High Dependency Unit
<i>HIS</i>	Healthcare Improvement Scotland, an independent regulatory body for all healthcare in Scotland
<i>HIW</i>	Health Inspectorate Wales, an independent regulatory body of all healthcare in Wales
<i>HIW</i>	Health Inspectorate Wales, an independent regulatory body of all healthcare in Wales
<i>HMT</i>	Hospital Management Trust
<i>HPA</i>	Health Protection Agency
<i>ICU</i>	Intensive Care Unit
<i>IFSO</i>	International Federation for the Surgery of Obesity and Metabolic Disorders
<i>ITU</i>	Intensive Treatment Unit

<i>IVF</i>	In vitro fertilisation
[X]	[X]
<i>L&B</i>	Laing & Buisson, providing intelligence on the healthcare market across the UK
<i>LFC</i>	London Fertility Centre
<i>Managed Care</i>	A variety of techniques used by PMIs to reduce medical reimbursement costs. These include open referral, direct referral, and “fee capped” programs.
<i>MRI</i>	Magnetic resonance imaging
<i>NHS</i>	National Health Service
[X]	[X]
<i>Nuffield Health</i>	Private healthcare provider
<i>Obera balloon</i>	Weight loss treatment
<i>OFT</i>	Office of Fair Trading
<i>OP</i>	Out Patient
<i>OPD</i>	Out Patient Department
<i>PET Scanner</i>	Positive emission tomography scanner
<i>PH</i>	Private healthcare
<i>PHIN</i>	Private health information network (previously known as Hellenic Project)
<i>PHPs</i>	Private healthcare providers
<i>PIP implants</i>	Poly Implant Prothèse breast implants
<i>PMIs</i>	Private medical insurers
<i>PPUs</i>	NHS private patient units providing private healthcare
<i>PROMS</i>	Patient reported outcome measures- the results of surveys carried out across the sector
<i>Ramsay Healthcare</i>	Private healthcare provider
<i>Spire</i>	Spire Healthcare Group
<i>SSD</i>	Sterile Services Department
<i>SSNIP</i>	Small but significant non-transitory increase in price
<i>TAVI</i>	Transcatheter Aortic Valve Implantation
<i>Theory of Harm</i>	Area that the CC has identified as potentially hindering competition
<i>YAG Laser</i>	Laser eye treatment