

PRIVATE HEALTHCARE MARKET INVESTIGATION

AXA PPP: RESPONSE TO THE ANNOTATED ISSUES STATEMENT

This document sets out the response of AXA PPP healthcare Limited (“**AXA PPP**”) to the Annotated Issues Statement (“**AIS**”) received from the Competition Commission (“**CC**”) on 28 February 2013 as part of the CC’s market investigation reference (“**MIR**”).

AXA PPP has made submissions to the CC on 20 July 2012 and 15 November 2012 in response to the CC’s Statement of Issues. Where AXA PPP agrees with the CC’s AIS thinking, AXA PPP does not repeat its previous submissions in this response.

In this response, AXA PPP makes further submissions (i) on additional issues for it as an insurer and related additional evidence to assist the CC, particularly on consultant incentives; and (ii) commenting on the AIS thinking and providing further clarification and/or evidence. Our response is set out in two parts:

- Part 1 – Summary response
- Part 2 - Incentives
- ✂✂

PART 1 – SUMMARY RESPONSE

1 EXECUTIVE SUMMARY

1.1 AXA PPP broadly endorses the CC’s AIS thinking. However, AXA PPP submits that the importance of certain issues requires greater emphasis as the CC prepares its Provisional Findings (“**PFs**”). Moreover, given the range of issues in the AIS, AXA PPP believes that more prioritisation is appropriate. It focuses below on the three most critical issues in order of their importance to the costs of private health insurance:

1.2 Issue Number 1: HCA’s market power in London

- ***London should be given more prominence in the analysis and PFs.*** This analysis deserves to be the first chapter in the CC’s assessment of local competition in private hospital markets because (i) London has several unique aspects, not least that it is the largest and most important of the UK’s private hospital markets (worthy of a MIR in its own right); and (ii) London also contains the most compelling examples of adverse effects on competition (see below). For these reasons, AXA PPP respectfully urges that London should be the main issue for the CC’s investigation and the PFs.
- ***HCA’s market power adversely affects private hospital competition in London.*** This is paramount among the key issues facing the CC. While AXA PPP urges a nuanced assessment of London and therefore, inextricably, of HCA’s market position, it is not inappropriate to draw a very broad parallel between BAA’s historical common ownership of three of the key five London-area airports and HCA’s common ownership of six of seven “must haves”¹ of the elite private hospitals in Central London – in each case, the strong competition that would otherwise exist between these businesses is internalised (i.e. neutralised) within

¹ “must haves” are those hospitals AXA PPP defines as essential for large corporate clients and for individual clients based in and around London and the south-east.

one firm. In dealing with HCA, AXA PPP, despite its own size and degree of buyer power, has been consistently unable to resist cost inflation imposed by HCA, which AXA PPP is obliged to pass on to London customers in the form of higher insurance premiums than if the London market were a properly functioning competitive market. AXA PPP sets out the supporting aspects of this conclusion in more detail below.

1.3 Issue Number 2: Consultant incentives that distort competition

- ***The AIS is missing a crucial theory of harm: the distortive effects of consultant incentives to refer patients (distorting choice and/or deterring entry) and/or commissioning excessive treatment (inflating costs).*** While medical specialists endeavour as part of their professional ethical obligations to act in the best interests of patients, consultants are far from immune to responding rationally (if often sub-consciously) to financial incentives that, in this case, distort competition by raising entry barriers and leading to cost inflation. The United States has recognised that financial incentives can have a pernicious effect on patient welfare, and has introduced legislation banning financial interests. In the UK, and especially in London, the prevalence of consultant incentives presents a growing competition problem which is inadequately recognised and inadequately addressed to date.
- ***Incentives to commission unnecessary/excessive treatment.*** Incentives to refer where the consultant is part owner or as a quid pro quo for other inducements raise barriers to entry and expansion, and are designed to distort the market for disinterested medical advice. Incentives to 'gold-plate' diagnostic tests and/or treatment to recoup equipment costs undermine (i) efficiency; and (ii) also confidence in proper 'market' pricing of treatment episodes. In addition, the 'incentives' serve no economic or welfare purpose in a system in which professionals are bound to exercise professional judgement and in which they can be properly and professionally paid without such incentives (as now applies in the United States as a result of a ban).
- ***There is a self-reinforcing cycle that creates dominance.*** Consultant incentives create exclusive/'tied' arrangements, motivating consultants to take advantage of information asymmetry to 'gold-plate' treatments and leading to a perverse, self-reinforcing cycle: those players who are most efficient at implementing the incentives/consultant 'lock in' effect, can increase profit margins to afford even greater incentives and ultimately create dominant positions.
- ***Increasing sophistication of incentive models.*** In Part 2 of this response, AXA PPP presents a number of different incentive models that have grown up in the market. These range from straightforward payments per test, through more complex profit-sharing and up to joint ownership models. It is our view that whatever the details of these particular arrangements their intention and their effect is to lead to excessive treatment, 'gold-plating' and barriers to entry or expansion for other competitors.
- ***Current regulation of the profession by the GMC is weak.*** The body with responsibility for regulation of the medical profession is the General Medical Council ('GMC'). Its role is to ensure that doctors who are on its register are fit to practice. The hurdle for removing a doctor from the register or restricting a doctor's right to practice is set high and evidence standards are set at what AXA PPP considers to be at court levels, i.e. beyond reasonable doubt. It seems that in deciding to remove a doctor the GMC will need to be convinced that what an individual doctor has done is out of step with his or her peers. The fact that incentives are widespread may therefore result (wrongly, in AXA PPP's view) in such practices being somehow legitimised. The way the GMC operates produces weak regulation and a bias

towards a doctor's need to continue practising as opposed to protecting the public. Moreover, it certainly has no remit to protect competition.

- On 25 March 2013 the GMC issued an updated version of its guidance on financial arrangements and commercial arrangements and conflicts of interests. AXA PPP believes the new guidance and the remit of the GMC remain inadequate to remove referral incentives, which AXA PPP strongly believes should be the remedial action of an effective regulator, in the face of current evidence relating to overtreatment and adverse impact on competition through 'tied' arrangements.
- AXA PPP's view is that no reliance can be placed on the GMC to tackle the interference with competition in the market and the consumer detriment that incentives pose. It is strongly of the view that other remedies are needed and is very concerned at the current position. AXA PPP notes that in the USA there has been considerable government action to limit and stop such incentives through the law. Similar action is necessary in the UK.

1.4 Issue Number 3: Anaesthetist consultant groups that exercise local market power

- The AIS correctly identifies that the creation of anaesthetists (and other) specialist groups with common pricing adversely affects competition and drives up costs. In addition to its case study on \times , AXA PPP provides further examples and evidence below, which indicate that any remedy needs to be general in its application.

1.5 Other issues

- As set out below, AXA PPP wishes to comment in a more limited way on the CC's current thinking in respect of the following issues:
 - (a) *Market definition for medical treatment* – although in many contexts outpatient, day-patient and inpatient activities are not directly substitutable, it is important to recognise that all types of setting may be utilised within a patient's treatment episode. Focusing on only one type of treatment setting in isolation risks missing important aspects of the treatment pathway within which competition may be frustrated, and AXA PPP would urge the CC to continue to assess all types of treatment.
 - (b) *Buyer power of insurers in respect of individual consultants* – in summary, AXA PPP submits that the prevention of 'top-up' fees contributes to consumer welfare by constraining price inflation to consumers in insurance premiums, whilst not materially restricting patient choice.
 - (c) *PMI's bargaining buyer power in respect of hospital groups* – in AXA PPP's view, the issue is not whether PMIs have a degree of buyer power as a matter in and of itself, the issue is whether this degree of buyer power is sufficient to neutralise supply-side market power. While PMIs' degree of buyer power is a positive and mitigating factor to constrain hospital market power up to a point (because otherwise prices would be higher still), it is not a panacea, most acutely in relation to (a) HCA in London \times . AXA PPP's position is that we would always seek to push back vigorously against any pressure not to recognise new hospitals which could offer price, quality or choice benefits in a local area. We are concerned, however, that the commercial impact on AXA PPP could well be disproportionate, specifically in relation to HCA, and that this will be reflected in higher prices to consumers. \times
 - (d) *Barriers to entry* – AXA PPP considers that PMI's have not in fact been unreasonably deterred from recognising new hospitals as a result of the prospect of losing volume related discounts, or by threats of substantial price rises if volumes are reduced. Our

position is: if a change in the incumbent hospital's price is made to reflect the loss of local patient volumes, then this would seem reasonable. However, the threat of broader action by that incumbent threatening to leverage its broader network, including solus hospitals, is where problems arise, as noted in (c) above.

- (e) *Uniform pricing between AXA PPP and private healthcare provider groups* ✗.
- (f) *Market share methodology* – AXA PPP believes the CC methodology risks both understating and overstating market power in different circumstances.

Evidence supporting the above propositions is set out below (including references to evidence already submitted).

2 HCA'S MARKET POWER ADVERSELY AFFECTS PRIVATE HOSPITAL COMPETITION IN LONDON

The most relevant market is the supply of elite private hospital services in London

- 2.1 AXA PPP views elite private hospital services in London as a separate relevant market for the CC's assessment of an adverse effect on competition ("AEC"). Despite efforts by other interested parties to blur the picture in London, market definition is a framework for competitive assessment of the strength and immediacy of competitive constraints, not an end in itself, and the boundaries of an appropriate market need not be rigid. In this case, the issue of product and geographic market definition are intertwined.
 - 2.2 London's elite private hospitals are characterised by a "virtuous circle" of:
 - (a) their UK-wide and indeed international **reputation** for excellence, attracting high profile specialists and elite facilities; and coverage of the **full range of high-acuity** treatments (compared to specialising in only one, for example);
 - (b) their leading role in introducing technological **innovation** in the UK; and
 - (c) their **proximity to work and/or home of London commuters / residents** and in particular the critical London-based prime corporate customer base for private healthcare.
 - 2.3 London also comprises a vital element of demand: corporate customers with employees in the south-east contracting with PMIs, which then need to contract with HCA to provide services with those characteristics.
 - 2.4 In another sector there might be sufficient marginal customers who would switch to alternatives (e.g. hospital options in the Home Counties/South East). The nature of demand in London means that AXA PPP and its PMI competitors do not have marginal demand to leverage in negotiations; London's elite private hospitals (i.e. HCA) are a must-have and the one-in, all-in approach to hospital negotiation for inclusion in a PMI network means that the choice is binary - either a PMI has a credible London offer for its corporate customers or it does not. In short, corporate customers who have employees in the south-east require AXA PPP and other PMI providers to contract with HCA.
- HCA has very substantial market power in the provision of elite private hospital services in London***
- 2.5 Within Central London HCA benefits from a substantial market position via its ownership of elite facilities and management of certain high profile Private Patient Units ("**PPU**"), reinforced

by its interests in primary care facilities. HCA owns six of the elite private hospitals in Central London; these face only limited constraint from other facilities in the same area. Our analysis illustrates that over 80% of complex procedures performed in central London are performed in HCA facilities.

2.6 To appreciate fully HCA's position, it is necessary to consider the following cumulative and inter-related considerations:

(a) ***London's elite private hospitals are distinguishable from other London-area hospitals based, inter alia, on provision of the full-range of high acuity treatments***

2.6.1 Within London, certain hospitals are clearly 'must have' for servicing Corporate Customers which have employees in the south-east. Another advantage is that senior decision-makers are often based in London and have a desire to achieve the 'best' access for themselves. 80%

2.6.2 PPU's unaffiliated with HCA are not an effective constraint. Many PPU's are unlikely to be strong providers with a good reputation across a broad range of specialisms, as a result of their current small size and the fact that many are located within existing NHS facilities that cannot easily be expanded significantly, even with investment.

2.6.3 As set out in our submission of 15 November 2012, the 16 NHS PPU's in Central London are of differing sizes and a number of them are highly specialised (for example, Moorfields Eye Hospital). The total number of patients and beds in PPU's is small for historical reasons. These PPU's also share key clinical facilities, such as theatres and radiology with the NHS, which can mean that private patients' theatre lists have to wait behind NHS patients with higher clinical priorities. Investment in these facilities is also variable, many of them consisting only of private rooms in an NHS environment, as opposed to facilities that are more directly comparable with private hospitals.

2.6.4 Similarly, private hospitals in London that offer limited, highly specialised high-acuity treatment (such as Moorfields) are not effective competitors on the range of services provided by the elite hospitals. As a result, they are not considered credible alternatives.

2.6.5 As we have stated previously, certain London consultants and London facilities (in terms of technological advancement, complexity/scope of treatment and range of services) have a reputational draw, and these are mostly HCA facilities. The presence of "leading edge" equipment such as the Cyberknife can enhance the reputational draw of the facility, attracting consultants who wish to use it. It should be noted that the very high levels of capital investment associated with these new technologies makes some form of consultant incentive model even more crucial to the commercial strategy of these hospitals. This will then lead to a lowering of the threshold for using this technology, leading to unnecessary cost without concomitant additional benefit to the patient.

2.6.6 In summary, as HCA comprises most "must-have" elite private central London hospitals, HCA has significant market power – it is a "must-have" facility owner and of central importance to customers, particularly for large corporate customers with employees in the south-east.

(b) ***HCA's market power in private hospitals is reinforced by its 'horizontal integration' as operator of certain key PPUs***

2.6.7 HCA's control of certain PPUs within NHS facilities represents a neutering of potential competitive constraints. Some NHS facilities, because of their reputation and expertise, have the potential to provide much more significant competitive constraint than other PPUs. A clear example of this is the development of the PPU at Guy's and St Thomas which is now to be managed by HCA. This follows the acquisition of management rights by HCA over the UCH PPU, which had the potential to constrain HCA, in 2006.

(c) ***HCA's 'vertical integration' into London-area outpatient and diagnostic centres raises barriers to entry and reinforces its position on the elite London hospitals market***

2.6.8 HCA's horizontal and vertical integration in relation to a range of outpatient and diagnostic centres, including those in selected wider London areas such as Brentwood, New Malden and Sevenoaks, and private GP facilities, including Roodlane, Blossoms Healthcare and GenMed, raises additional cause for concern since they enable HCA to channel patients to its hospitals.

2.6.9 That HCA exercises further vertical integration through its use of partnership arrangements, in which it may also have some ownership and / or for which it provides funding in the form of loans, (such as Leaders in Oncology Care ('LOC') and Robotic Radiosurgery LLP) is also of concern; these tie key consultants into a partnership arrangement and, together with incentive arrangements, create a tendency to refer to other facilities in the group, foreclosing competitor access to customers.

(d) ***HCA incentives to Harley Street consultants further reinforce its market power***

2.6.10 Control of the start of the patient pathway is an important part of the treatment outcome but also of the competitive process. Typically all treatment will be carried out within one hospital or hospital group. Therefore, 'capturing' and 'retaining' the consultant is 'key' for the hospital or hospital group since in capturing the consultant it will also capture the patient. These incentives are described in detail in Part 2 of this paper.

2.6.11 AXA PPP notes (in Appendix E, paragraph 58 of the CC's AIS) that HCA informed the CC that its professional services agreement had been amended to read that the *clinician "shall be under no obligation to refer patients to any [HCA] hospital"*. AXA PPP understands from the CC's AIS document that similar amendments had been made, in 2012, to the partnership or shareholder agreements of other entities including Roodlane and LOC. AXA PPP understands that HCA may have had more direct contracts in the past ✕

2.6.12 AXA PPP believes that HCA has invested very significantly in these arrangements and it is not credible that they have done this without strong commercial rationale. HCA has stated that consultant incentives are a core part of its strategy, ✕ We refer the CC to the following:

- (i) HCA has stated its policy in its share prospectus, which is that it has a policy of financial engagement and that it seeks to structure arrangements within safe harbours in the US (see Part 2, section 3)²; and
- (ii) The fact that despite HCA's \$1.7Bn fine in 2003, it was again fined for illegal kickbacks in September 2012.³

2.6.13 ✕ In our view therefore, the CC should continue to consider actions which will ensure the use of financial incentives offered by hospital operators in the private healthcare industry are discontinued permanently.

Analysis separated by speciality / high acuity cluster

2.7 The CC has identified 16 specialties that account for 75% of total revenue at the hospitals of the five largest hospital groups.⁴

AXA PPP agrees that oncology ought to be considered separately, given its size in the market as a whole and its significance in the London market. We have analysed AXA PPP claims data for treatments in the 2012 calendar year by specialty for the top 5 groups, and identified a further 4 specialty areas that we believe the CC should consider separately.

Table 1

Data from all AXA PPP stays in 2012	Specialty as % of hospital group STAYS					
Specialties	BMI	HCA	Nuffield	Ramsay	Spire	% Total Volume of Stays
Orthopaedics/Trauma						
General Surgery						
Cardiac						
Neurosurgery						
These specialties as % of all stays in 2012						
Data from all AXA PPP stays in 2012	Specialty as % of Total Benefit Claimed					
Specialties	BMI	HCA	Nuffield	Ramsay	Spire	% Total Benefit Claimed
Orthopaedics/Trauma						
General Surgery						
Cardiac						
Neurosurgery						
These specialties as % of all benefit claimed in 2012						

2.8 In relation to high acuity treatments, the following specialties are important to examine in the context of the UK market as a whole and in central London in particular due to their concentration:

² HCA Inc share prospectus 2011 <http://www.nasdaq.com/markets/ipos/filing.ashx?filingid=7440880>

³ Link to the 2003 Department of Justice release: http://www.justice.gov/opa/pr/2003/June/03_civ_386.htm

Link to the 2012 Department of Justice release: <http://www.justice.gov/opa/pr/2012/September/12-civ-1133.html>

⁴ BMI, HCA, Nuffield, Ramsay and Spire.

- Cardiac – encompassing cardiology (medical and non-invasive surgical treatment of heart disorders) and cardiac surgery. This has been identified by the CC as a particular strength of HCA and forms 30% of their stays and 30% of benefit claimed in AXA PPP's data, a larger proportion of benefit claimed than oncology, whereas it is only 10% of benefit claimed in the other groups.
- Neurosurgery – this is carried out in all of the 5 groups but is particularly significant in HCA where it forms 30% of stays and 30% of benefit claimed, compared to around 10% of benefit claimed in the other groups.
- The additional specialties are discussed later in this document.

2.9 AXA PPP sets out below information on the relative number of ICU and HDU beds, theatres and consulting rooms in the elite group of private hospitals in central London, based on 2011 data. HCA accounts for a significant proportion of consulting rooms, theatres and ICU/HDU accommodation.

Table 2

London Elite Hospital facilities	ITU	HDU	Beds	Theatres	Consulting Rooms
BMI Weymouth Street	0	0	17	4	8
Bupa Cromwell	7		99	8	22
Hospital of St John & St Elizabeth		3	60	5	30
London Clinic	11		181	11	74
King Edward VII	2	2	56	3	6
Parkside		5	85	4	21
Royal Marsden*	12	7	21	5	8
HCA Harley Street Clinic	22	10	64	4	23
HCA Lister Hospital	0	2	76	4	20
HCA London Bridge	8	4	92	7	51
HCA Portland	3	3	86	3	40
HCA Princess Grace	4	2	101	8	48
HCA Wellington	25	45	266	11	64
HCA TOTAL	62	66	685	37	246
OVERALL TOTAL	94	83	1204	77	415
HCA %	66%	80%	57%	48%	59%
Data from 2011					
* Note NHS hospital so theatres, ICU and HDU are shared with NHS (across 2 sites, Fulham and Sutton), 21 beds are private					

2.10 It is clear from the above data that HCA has a particularly strong position in the key specialties of oncology, cardiac and neurosurgery. This is also reflected in its share of ITU and HDU beds. The dominance in these specialties contributes to their 'must have' status. 30%

3 CONSULTANT INCENTIVES THAT DISTORT COMPETITION

3.1 In a properly-functioning competitive market, consultants would compete on the quality and cost of patient care, that is to say, compete to act in the best interest of the patient, as medical ethics require, in an efficient manner.

- 3.2** As the CC is aware, consumers of medical services lack the knowledge to make informed judgments as to whether treatment is excessive or inadequate. They are unlikely to doubt or challenge consultant advice in favour of more treatment. Nor do they feel the cost of inflated treatment directly (other than diffusely, in the form of higher insurance premiums). Taken together, it is not surprising that the conditions facilitating unnecessary and/or excessive treatment exist. AXA PPP has seen consistent evidence that these conditions have been exploited by incumbent market participants, resulting in a widespread culture of incentive payments in the UK.
- 3.3** These payments are made by private healthcare providers to consultants, adversely influencing the consultant's professional judgement by encouraging overtreatment, inefficient use of resources and commissioning of overpriced services. AXA PPP considers such practices are both a cause and symptom of distorted competition in private healthcare provision and consultant services; they are however contrary to General Medical Council ("**GMC**") guidance⁵ and increase costs to the detriment of patients.
- 3.4** AXA PPP is aware of strong motivation on the part of providers to recoup the cost of investments in new equipment through incentivising increased utilisation. Such additional treatment is not necessary for patient welfare as doctors are obliged to arrive at diagnosis properly and do not require incentives in order to ensure necessary tests are carried out. It is also potentially adverse to diagnostic and therapeutic need and, even if in most cases not harmful, is nonetheless "gold-plating" to drive up cost rather than responding to patient need
- 3.5** The most striking large-scale study⁶ was undertaken in the United States comprising 18,000 patients with the insurer United Health. It showed a clear (and vast) increase in the incidence of tests being ordered compared to the baseline (where the doctor has no interest at all), when he can claim fees for interpretation and again, when he also bills for the facility. For stress echocardiography the increasing likelihood of tests being ordered was **7.1 times more likely** if the doctor also charged fees for interpretation and **12.8 times more likely** if the doctor charged fees for the use of the facility as well. It would be naive to assume that British consultants, compared to their American counterparts, are not economic actors that respond, even subconsciously, to clear economic incentives. ✂

Example: Case Study – ✂

- 3.6** AXA PPP has chosen this one example as it encapsulates a number of the issues endemic in the PH market, including local consultant groups, consultant drag and inappropriate financial incentives to consultants. The combination of these is a significant source of market power which AXA PPP believes should be assessed as a separate theory of harm on the distortive effects of consultant incentives.
- 3.7** ✂
- 3.8** ✂
- 3.9** AXA PPP has recently become aware that:
- (a) A number of ✂surgeons from the local area have, or are in the process of moving their practices to the ✂ hospital⁷;

⁵ See our submission dated 20 July 2012, section 17. In the United States many of the types of incentive AXA PPP understands have become more prevalent in the UK have been made illegal and have led to large fines.

⁶ See 'Association between Physician Billing and Cardiac Stress Testing Patterns following Coronary Revascularization' - JAMA November 9, 2011- Volume 306, No,18. .

⁷ The ✂ website lists 15 ✂, far more than any other speciality.

- (b) Some or all of these surgeons have some level of ownership of the hospital operation (X); and
- (c) These surgeons are members of a local consultant group, X .
- 3.10** AXA PPP has undertaken an initial investigation of these arrangements. AXA PPP has reviewed its dealings with the X for any declaration of doctors' interests and has specifically reviewed:
- (a) The hospital website X;
- (b) X;
- (c) X website and some of their accounts; and
- (d) X accounts and annual return.
- 3.11** To date, AXA PPP has not been able to identify any declaration of financial interest on any of these sources. The arrangement is not transparent and AXA PPP believes it does not comply with GMC guidance. In addition, the webpage giving information for referring GPs gives no indication of financial interest. The X website and its paper invoices give different company details. The former gives the company number of X and the latter X.
- 3.12** When X consultants have sought to authorise out of network exemptions⁸, they do not disclose financial interests, indeed the letters imply a degree of distance. For example, a letter from the Director of X of January 2013 states:
- "I have been asked to contact you by X regarding the continuing issues of getting AXAPP patients operated on in X.*
- There is currently a blanket ban on patients being operated on at the new X Hospital by AXAPP-*
- I have no desire to get involved in the politics of this.*
- From a surgeon point of view in December I made the decision to move to the X based on the clinical specification it had and the staff mix and support I received."*
- 3.13** Some consultants have suggested to AXA PPP that they *"have been unable to get theatre slots at the X"*. However, the X hospital Director has confirmed that they have no issue obtaining time in the X theatres (X). Further, an analysis of billing indicates that consultants from X appear to generate 88% of billing in X for X services X a .
- 3.14** The arrangements described above, suggest the combination of a consultant group, a new entrant with equity holding by consultants and consultant drag as a result of this inappropriate incentive are significantly distorting competition. In negotiations with PMIs, because of its local monopoly in the key specialty of X surgery, PMIs will have no choice but to recognise this facility as the alternative would cause significant customer disruption. In addition the terms on which it would be recognised would be more favourable to X than would otherwise be the case. Furthermore, the ownership structure motivates overtreatment.
- 3.15** AXA PPP therefore urges the CC to consider a new theory of harm, in which these types of combinations have a very high level of local market power, resulting in:
- (a) Customer detriment through lack of choice / local monopoly

⁸ That is, treatment received at a non-network facility (such as the X) on medical necessity grounds because of the lack of facility locally in AXA PPP's network.

- (b) Direct or indirect incentives to consultants which will distort choice and restrict competition; and
- (c) Imposition of higher treatment episode costs which will harm customers through higher premiums.

3.16 As suggested elsewhere in this response, direct and indirect financial incentives should be banned, as they have been by the Stark Laws and the Patient Protection Affordable Care Act in the United States (see Part 2, section 6).

4 MARKET POWER OF CONSULTANT GROUPS IN CERTAIN LOCAL AREAS

4.1 Consultants acting in groups in certain local areas have market power, particularly anaesthetists groups. This market power results in a reduction and/or removal of patient choice and is likely to result in higher prices. Anaesthetist groups also appear to restrict the professional choices made by surgeons, as the surgeon typically has no choice but to use that anaesthetist group and may not know which anaesthetist will arrive on the day. Competition between anaesthetists is therefore restricted.

4.2 AXA PPP submitted evidence in its response to the Issues Statement of the behaviour of anaesthetist groups in X, and further evidence in the Market Questionnaire regarding X. It also believes that the following groups are able to exercise market power in their local area:

- (a) X.

Example: Case Study

In support of the CC's further work in this area, AXA PPP has carried out more in-depth analysis of the X a partnership which controls 80% of private anaesthesia in X. The analysis suggests that:

- (a) The X, on average, charges 50% to 80% more than their colleagues in X. They make charges for full preoperative assessments⁹ (all joint replacements and other operations) approximately five times as frequently as the national average. In 2011, 14% of X patients had additional charges for full preoperative assessment against a national rate of approximately 3%. In a large number of cases X has quoted X Hospital Protocol as the reason¹⁰. These charges are not typically paid by AXA PPP as it considers full preoperative assessment a necessary part of patient care for the procedure in question, not a separate procedure.
- (b) The X group clearly operates a single fee schedule for all its anaesthetists as it quotes one price for each treatment on its website.
- (c) Even when the full preoperative assessment charge for the procedure in question is routine the website does not include it in the on-line quote given to prospective patients, and there is no warning that there would be additional preoperative charges. AXA PPP does not dispute that full preoperative assessments are sometimes necessary; it is however part of the anaesthetic service for the procedure and should be included in the overall package, not invoiced as a separate service. Patients are advised by the website that X fees in some cases exceed insurance cover and therefore may not be covered by insurance but that in practice they probably will be

⁹ All patients need to be seen in advance of anaesthesia, but in some cases a full assessment with additional tests is performed. X is performing full assessments much more frequently than the national average.

¹⁰ AXA PPP has been unable to obtain any details of this "protocol" despite repeated requests.

reimbursed. This leads the patient to think that all the fees will in fact be covered by their insurance, with the result that the patients complain to AXA PPP that it has not reimbursed the full costs.

- (d) Patients who do not subsequently pay are referred to the X Debt Collection agency which enforces payments. AXA PPP is aware of four policyholders who were pressed to pay bills personally and who were given no warning that they would be billed for any additional charge.

4.3 Recently, an AXA PPP employee obtained a quotation for anaesthesia for knee replacement which is a procedure where additional charges are always made for preoperative assessment. The X website quoted £424 on 16 March 2013. No mention was made of the preoperative assessment even though the group charges all patients an additional fee for this. The actual fees levied by the group for an equivalent knee replacement procedure in 2012 consisted of a fee of £80 for a preoperative assessment and a fee of £416 for anaesthesia. X.

4.4 The X dominates anaesthetic services in X with the result that patients have to travel or pay fees which are not subject to competition and as a result are inflated. It also lacks transparency in its pricing resulting in unexpected patient bills. The charging of routine parts of the service as extra is a feature AXA PPP has also been carried out by the X (although, to date, we have not carried out an exhaustive search of other types of consultant groups).

Anticompetitive effects of consultants groups needs to be remedied

4.5 AXA PPP notes that the Office of Fair Trading (“OFT”) previously considered (in response to a complaint made in 2001) whether the activities of certain anaesthetist groups may be in breach of Chapter 1 of the Competition Act 1998 (“the Act”), but concluded that no action was necessary on the grounds that the groups in question were operating as single undertakings for the purposes of competition law (with the exception of one group which was not engaged in joint price setting).

4.6 It is apparent from the OFT’s non-infringement decision that the Act is not necessarily an appropriate tool to remedy the anti-competitive effects of anaesthetist groups. AXA PPP further notes that the Association of Anaesthetists of Great Britain and Ireland (“AAGBI”) guidance recommends that anaesthetists create legal partnerships with the specific aim of avoiding censure under competition law, stating “without a legally drafted partnership agreement, the group acting as a partnership will be regarded in law as a “sham” partnership and will not benefit from the legal advantages of a real partnership, such as the ability for all partners to charge the same fee without an accusation of price fixing”. It is interesting to note that the AAGBI encourages its members to maximise income and increase their bargaining power with insurers by means of these groups.¹¹

Under the heading of “Chambers and Group Practice”, it says (*inter alia*):

“The advantages of group practice

Maximising: Income

Free and off-call time

Strength in negotiating with private hospitals, Treatment Centres and PMIs.”

¹¹ AAGBI – Independent Practice, April 2008

4.7 In AXA PPP's view there may be some instances where the activities of certain anaesthetist groups may be in breach of either Chapter 1 or Chapter 2 of the Act. To the extent that the CC receives evidence to this effect, AXA PPP would encourage the CC to bring such evidence to the OFT's attention. However, AXA PPP strongly believes that the CC should in parallel consider separate action to remedy features of the market which clearly restrict competition and result in consumer detriment, whatever their legal form, in order to ensure that a holistic solution with sufficient deterrent effect is achieved.

5 AXA PPP'S FURTHER SUBMISSIONS

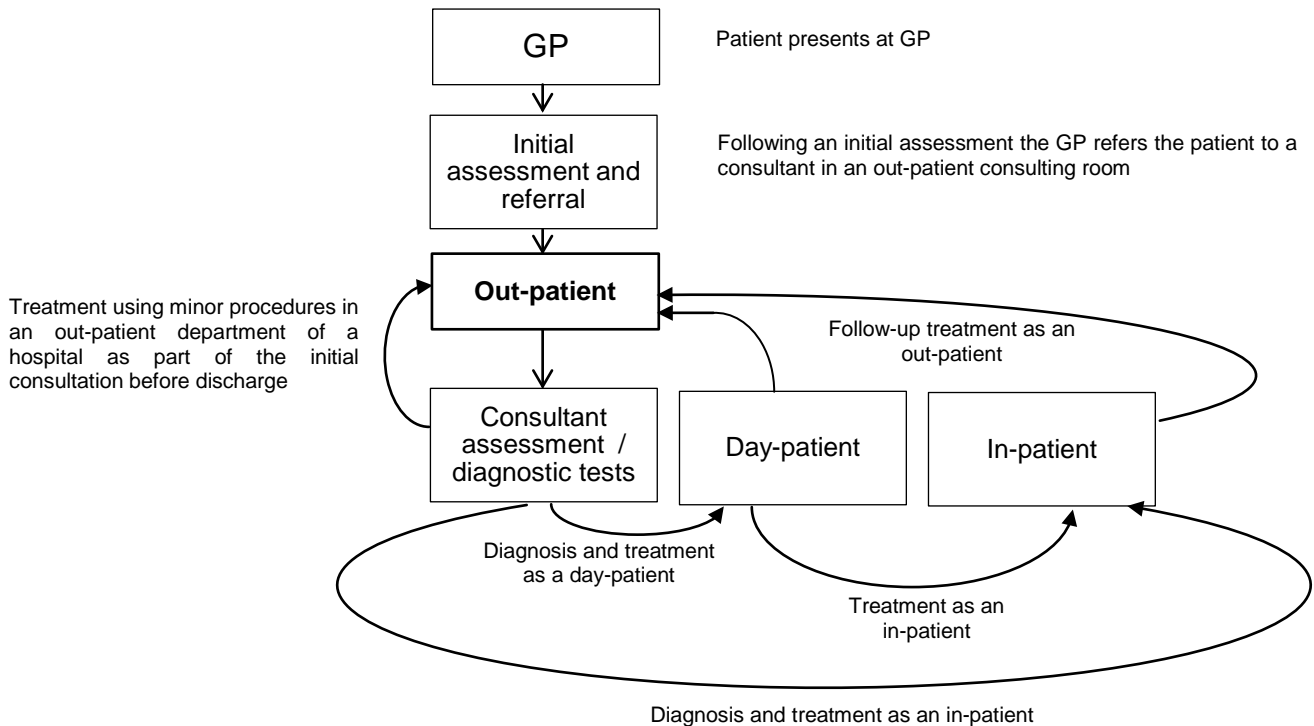
5.1 Where AXA PPP wishes to comment on the CC's AIS thinking, it makes the following submissions.

(a) ***Inpatient, Day-patient and Out-patient care are not wholly distinct product markets***

5.2 Although in many contexts outpatient, day-patient and inpatient activities are not directly substitutable, in considering these markets separately, however, it is possible the CC will miss important aspects of the treatment pathway in which competition is frustrated.

5.3 The product markets for medical treatment inpatient, day-case and outpatient settings work together and are interdependent for many treatment episodes. The interaction of all three care settings is summarised in the diagram below.

Medical Treatment



The customer journey can encompass all stages of care from the GP, via one or more consultants in an out-patient setting to diagnostic tests in out-patient or investigations (such as endoscopy or biopsy) as a day-patient, to either day-patient care or in-patient care for surgery or further diagnostic medical work, and back to out-patient for follow-up and post-operative care.

- 5.4** As set out above, outpatient treatments provide the input to subsequent inpatient and day-patient treatment, and inpatient treatments lead to further outpatient services. In addition, certain treatment may be carried out in more than one setting depending on the patient, the method of surgery and sometimes the preference of the surgeon.
- 5.5** For example, the vast majority of cataract operations could be undertaken on an outpatient basis with local anaesthetic using eg. eye drops. Only a small minority is likely to need general anaesthetic for medical reasons and some will be done as day-patients due to the use of sedation. However, our belief is that some surgeons continue to use general anaesthetic, when local could be used, thereby increasing the cost of the procedure. This adds costs to claims and ultimately adds to consumer insurance premiums.
- 5.6** For intermediate operations such as hysteroscopy, and for major operations such as arthroscopic operations on the knee, inpatient and day-patient may both be options.
- 5.7** ✕.

i) Control of the start of the patient pathway is clearly the key determinant in deciding where all of the subsequent treatment takes place. The costs of the episode of treatment are therefore largely determined at the outset. Patients are generally extremely reluctant to query the expert judgement of their doctors, and even if minded to, lack the information required. A number of hospital submissions have also noted the importance of the consultant in decisions about where the patient is treated. AXA PPP believes that the significance of this control of the start of the patient pathway explains the desire of some hospital groups (especially HCA) to invest in, or otherwise control, vertical integration in primary care and outpatient facilities. Vertical relationships between treatment settings therefore reinforce market power

ii) Insofar as particular treatments can be performed either within an inpatient or day-case setting, or a day-case or an outpatient setting, as the case may be, then extension for example by HCA into outreach facilities and organisations such as Leaders in Oncology Care represents a further example of horizontal consolidation of the market.

Vertical relationship between treatment settings reinforces market power

- 5.8** In focusing on inpatient treatment only, significant distortions of competition could be missed or understated. Incentives offered by hospital operators to consultants to perform treatment in places where they have a financial interest have particular significance in the movement from one stage of the customer journey to the next, making these vertical linkages particularly important.
- 5.9** AXA PPP has grave concerns where reliance on the consultant is combined with issues of vertical integration and with specialist incentives. Primary care advice and outpatient treatments can and do constrain where subsequent inpatient and day-patient episodes take place. That the first stage of treatment is an input to the next is, therefore, very significant. The interdependence of treatment settings is particularly acute in the context of HCA's market power and vertical integration in London (as discussed above).
- 5.10** AXA PPP has previously provided a relevant case study as part of its submission in response to the Issue Statement in July 2012. ✕ which illustrates the power of the consultant to determine where diagnostic tests are carried out, even where they are contrary to the wishes of the patient, and the significance of financial interests in these decisions.

Local competition and new entry in relation to provision of medical treatment

- 5.11** AXA PPP considers that in some areas the addition of an outpatient facility is unlikely to be very helpful in terms of price. In theory, moving treatment from an inpatient facility to a potentially more efficient day-patient or outpatient setting should be good for competition. However, in practice, an insurer is still faced with a solus supplier of inpatient services who now has a fixed cost recovery problem. So in the round an insurer may see little if any price benefit to customers, although quality and/or choice may be better.
- 5.12** Where there are many hospitals (e.g. in central London), the introduction of new day-patient or outpatient facilities is much more likely to have a potentially positive effect. This is because an insurer could then make extensive use of these facilities, contracting with a smaller number of inpatient suppliers and hence drive real savings. However, this process is currently frustrated by one supplier having a dominant position in the London market. At the same time that supplier has embarked on a significant programme of vertical integration into the outpatient market. This is clearly an attempt to control the flow of patients, but it also prevents new suppliers coming into that market on an independent basis and offering some services that would compete more directly with HCA.
- 5.13** It is also important that new entrants, setting up outpatient or day-treatment centres, are considered as future competitors to existing inpatient treatment, as they could expand into these areas once established.
- 5.14** It is important for the CC to continue to review inpatient treatment in the context of the entire patient journey, and to include the early decisions made by consultants on diagnostic tests, treatment and location, which are integral to the costs of the episode of care as a whole.
- 5.15** The CC has requested suggestions for specialties in which it could carry out more product market analysis. Set out in Section 2, Table 1 are \times specialties which represent large proportions of the top 5 hospital groups' stays and revenue in AXA PPP's 2012 claims. Two specialties which represent the "bread and butter" of the larger groups and which AXA PPP suggests are further considered by the CC are: \times

(b) ***Buyer power of insurers in respect of individual consultants***

- 5.16** AXA PPP does not agree that patient choice is restricted in the market for the provision of consultant services through the prevention of 'top-up' fees.
- 5.17** AXA PPP's experience in collecting customer feedback is that consumers consider that top-up fees are an area where detriment can arise. Consumers want their insurer to control prices, and price is a very major concern for them.
- 5.18** Insurers have \times specialist fees, and as the CC recognises, in the absence of these controls from insurers, it is not obvious that there would be any constraint at all on fees.
- 5.19** AXA PPP is also concerned that, for a smaller number of extreme cases, the level of fees appears to take advantage of information asymmetry. For example, a number of ophthalmologists charge as much as \times per eye for cataract surgery (hospital and diagnostic fees would be in addition to this). Often this is based on an assertion that cataract surgery is difficult and complex, with significant risk. This is in AXA PPP's experience not a view that is shared by the wider body of the medical profession.

Consultant 'fee caps'

- 5.20** AXA PPP introduced a new system of managing fees in 2008 which applied to all specialists applying for recognition after that date. This was to ensure, to the extent possible, that fees could be met in full and that customers would not experience a shortfall. Under the new management system, the specialist was required to agree to a contract, the terms of which specified that recognition was contingent on the specialist agreeing to charge AXA PPP's customers in line with its published fee schedule and that the specialists would not seek to charge customers separately. Consultants recognised before 2008 were not required to sign a contract. The main reason for introducing this system was to enable AXA PPP to provide a guarantee to customers that they would not experience a shortfall if they saw one of these "Fee Assured" specialists.
- 5.21** ✗It would not be in insurers' interests to limit the supply of consultants, and the level of fees determined by AXA PPP is by no means a deterrent and is not designed to be one. For example, an NHS consultant earns in the region of £60 per hour and the relevant NHS Trust pays approximately £120 per hour for additional work.¹² In the private sector hourly pay is in excess of £450 (for example, a hip replacement takes 45-60 minutes and AXA PPP's published fee is £800).
- 5.22** AXA PPP has carried out a specific piece of analysis to verify the level of difference in procedure fees between consultants who were newly registered by AXA PPP from 2008 and consultants registered before that. This was based on consultant procedure fees billed in (a) 2007, prior to the introduction of fee assured agreements; and (b) 2011, after the introduction of fee assured agreements. At the start of 2007 there were c22,500 recognised consultants with c1,300 recognised during the year; in early 2011 there were c23,000 recognised and c1,300 recognised during the year. The proportion of new entrants has remained unchanged as compared to the total number of consultants in the market
- 5.23** The following analysis is based on the top 20 procedures as performed by new entrants.

Table 3 - Procedure Fees

Consultant Status / Year	2007	2011
Existing consultants (pre 2008)	✗	✗
New entrants (post 2008)	✗	✗

- 5.24** The table above demonstrates that in 2007 new entrants were billing on average around ✗ the national average for procedure fees, and in 2011 the difference had ✗ to around ✗ the national average. We do not perceive ✗ to be a major change.
- 5.25** AXA PPP has monitored the flow of new specialists before and after the introduction of the Fee Assured contract and seen no change (✗). Given the NHS and private sector fee differential described above, the fee level would need to reduce substantially (e.g. by ✗), before any deterrent effect may be expected to arise. In any event, AXA PPP monitors the position carefully.

¹² National Audit Office report Feb 2013 – Managing NHS hospital consultants

Prevention of 'top-up fees' enhances consumer welfare

5.26 AXA PPP considers that allowing PMI customers to be treated by consultants who charge materially more than their peers gives rise to customer detriment. This customer detriment arises as follows:

- (i) in economic terms the patient is charged an excessive fee (relative to the cost of the procedure). In this context a reference to "materially more" is a reference to a fee which is 2, or even 3 times what their peers are charging;
- (ii) there is no objective evidence that the service the customer receives or the clinical outcomes are better than their peers; and
- (iii) such excessive charges will be reflected in claim costs, thereby driving increased PMI premiums, detrimentally affecting all customers in that area of the country. A key objective for all PMIs is to keep premiums affordable, for the long-term good of customers and the PH and PMI markets.

5.27 For example, in relation to cataract surgery, improvements in technology and treatment techniques over time now mean that the majority of routine cataract procedures are capable of being undertaken in an outpatient setting within 15-20 minutes. However, some surgeons continue to charge as if the procedure required a long time in theatre and some anaesthetists continue to charge for general anaesthetic despite the fact that most operations are now carried out with local anaesthetic. AXA PPP's published fee for cataract surgery is currently £600. This compares to charges by certain ophthalmologists of ₤ for cataract procedures. For anaesthesia AXA PPP's published fees are £220 for general and £110 as a stand-by rate for local anaesthetic (given eg. as eye drops). This compares with up to ₤ for anaesthetic charges actually made by some anaesthetists.

5.28 AXA PPP considers that such excessive charges on the part of consultants are largely driven by customer information asymmetry. In referring patients to secondary care, neither GPs, nor insurers, nor patients can choose a consultant on the basis of objective outcome data, as it is clear that such data does not yet exist. AXA PPP works from the position that all consultants are of equal quality. To do otherwise (ie. by suggesting that those who charge more are "better") would suggest that the other consultants are "worse", and there is no objective evidence to support this.

The PMI market is highly competitive and customers are very price sensitive.

5.29 AXA PPP has sought to allow customers the option of whether to pay top-up fees whilst enhancing the choice of consultant through the introduction of an open referral mechanism to consultants whose fees will be met in full. Open referrals allow AXA PPP to contain cost, but only to the extent of excluding a small minority of specialists based on their episode costs and their fee levels. All of the specialists on the open referrals list (recognised pre and post 2008) meet AXA PPP's normal recognition criteria.

5.30 Customers have a choice to follow the open referral route or not. Certain of AXA PPP's corporate products mandate open referral and the choice as to whether to purchase these products or a 'full network' product rests with the corporate customer. The open referral

service is also open to AXA PPP customers who are not on open referral products and it is the customers' choice to use it.

- 5.31** Under the open referral mechanism AXA PPP offers a Fast Track Appointment Service where it offers to book the first appointment for customers in a location and at a time convenient to our customers. This service offers a better customer journey - the named referral process can involve the customer needing to return to the GP for another referral if the first specialist named is absent, has limited availability or is not recognised. For a corporate customer the benefit is that employee downtime can be reduced, for example as it allows the employee to choose an appointment close to work rather than home and at a time which is after work or which fits in with the employee's work diary.
- 5.32** To date, AXA PPP has processed in the region of \times open referrals in the last \times months. It monitors the quality of this process through customer satisfaction, timeliness of appointment and incidence of second referrals to a second consultant. All of these have shown very positive outcomes.

AXA PPP's open referrals are not managed care

- 5.33** At paragraph 143 to 145 of the AIS, the CC has noted that in the asymmetry of information inherent in the PH market and the current fee for service model, there is an incentive for the consultant to take advantage of the asymmetry in referring patients for unnecessary or more elaborate diagnostic tests.
- 5.34** We are aware that managed care has been used as a means to address these issues. However AXA PPP wishes to make it clear that it does not currently engage in managed care (in the sense of defining the treatment pathway or protocol), except in rare and exceptional circumstances, and does not interfere with or direct the type of treatment that our customers receive.
- 5.35** AXA PPP is very keen to avoid any situation where it might be said to encourage under-treatment; aside from clear patient risk, it would undermine its reputation and that of PMI generally. For clarity, AXA PPP is sending customers to specialists whose practice is in line with the great majority of their profession. It continues to reimburse specialists via the current 'fee for service' model, one which tends to drive intervention, and if AXA PPP did work with specialists to reduce costs this would be, for example, to get tests at a lower unit rate, not to interfere in the number of tests.

(c) ***AXA PPP does not have countervailing buyer power sufficient to offset hospital market power in all cases***

- 5.36** Although AXA PPP broadly supports the CC's emerging thinking in respect of market power of hospital operators in negotiations with insurers, \times . AXA PPP perceives the relative imbalance to be as follows:
- HCA – its dominance in central London market significantly outweighs AXA PPP bargaining power. AXA PPP's view in addition is that HCA has a clear tendency to seek to use its dominant position through \times ;
- $\times \times$
- ***Removal of a hospital from an insurer's network***
- 5.37** With regard to Appendix D, paragraph 25 and Appendix F, it is difficult for insurers to determine with accuracy the impact of client losses as a consequence, inter alia, of de-listing a hospital or hospital group, and there are few examples of this actually reaching such a

stage. Bupa appears to have lost about 6% of patient volume (from 2.87m at the end of 2011 to 2.69m by the end of 2012), the majority of this in the first 6 months¹³:

- 5.38 This contrasts a 3% increase in AXA PPP's UK population. ✂
- 5.39 We remain of the view that PMIs are significantly disadvantaged in their negotiations with hospital groups. ✂

(d) **Barriers to entry**

- 5.40 In paragraph 124 the CC asserts that PMIs may be deterred from recognising new hospitals by the prospect of losing volume-related discounts or by threats of substantial price rises if volumes are reduced. AXA PPP agrees that this may well be the case in some instances. For our part, we would always resist such pressure as strongly as possible in order to achieve the best possible outcome for our customers.
- 5.41 The CC should note that:

- 5.42 ✂ In Appendix E, paragraph 47, the CC has noted that "we have seen no evidence that hospital groups have the ability to deter entry by forcing a PMI to deny recognition to an entrant even if they have an incentive to do so". AXA PPP has some key examples where we have been under extremely strong pressure from the larger hospital groups to resist the recognition of new facilities. AXA PPP has resisted such pressure so far. These have been described in some detail in our previous submissions, as follows:

- i) ✂ Therefore, whilst AXA PPP accepts that operators have not in practice been precluded from entering markets, it remains concerned that any increase in competition as a result of new facilities being opened has led to an upward rather than a downward pressure on prices as a result of incumbent hospitals leveraging their broader market power and the risk of greater incentives being offered to consultants, which are then passed on to PMI providers and patients.

Hospital recognition is not a barrier to entry

- 5.43 AXA PPP notes (paragraph 118 of the AIS) that the CC has carried out three case studies of market entry / expansion, which, together with work on profitability and Theory of Harm 1, have indicated that entry is restricted. Also noted is that in many local markets, overall demand is not sufficient to support an additional, efficiently-sized private hospital. AXA PPP has provided further information regarding the three cases in point, as follows:

✂

- 5.44 ✂ .

- 5.45 ✂

- 5.46 ✂

✂

- 5.47

¹³ Source: <http://www.bupa.com/investor-relations/financial-information/financial-statements-and-presentations>

(e) **Uniform pricing between AXA PPP and private healthcare provider groups**

5.48 ✂ As AXA PPP is not party to the contracts hospital groups have with other insurers, it is only able to comment on its own position in response to the CC's statement in paragraph 17 of the AIS that *'typically, where a private healthcare provider owns a chain of hospitals, it negotiates a single price for a given treatment with each insurer that will apply at all, or almost all, of its hospitals'*.

5.49 ✂

(f) **Market share methodology**

5.50 ✂

(i)

5.51 Moreover, as the CC notes, there is the separate issue of assessing market power in London.

5.52 More generally, AXA PPP considers that the approach to assessing hospital market power towards PMI providers and their customers derives from whether a hospital is, or is not, a "must-deal" partner, the answer to which may have only a relatively loose connection with market shares in catchment areas.

6 CONCLUSION

6.1 For the reasons set out above, AXA PPP considers that there are three key drivers currently impeding effective competition in respect of private healthcare provision. These are (a) HCA's market power in London; (b) the widespread culture of incentive payments from patient referrals and unnecessary/excessive treatment through to ownership interests in hospital operators; and (c) the ability of consultant groups (and specifically anaesthetists) to exercise local market power.

6.2 AXA PPP believes that the adverse effects on competition require not only structural changes to the market, for example, by limiting common ownership of hospital operators within a local area, through to regulatory intervention. With regard to economic incentives of healthcare providers, AXA PPP notes that in the United States there has been considerable government action to limit and stop such incentives through law, and believes that similar action to address competition and market issues is necessary in the UK. ✂

AXA PPP: RESPONSE TO THE ANNOTATED ISSUES STATEMENT**PART 2 - INCENTIVES**

This part summarises AXA PPP's views in respect of incentives, together with supporting evidence.

1 Overview

1.1 AXA PPP objects to the payment of incentives to consultants because it creates or reinforces features of the market which:

- restrict competition by creating exclusive/'tied' arrangements which exclude competitors and create barriers to entry;
- motivate consultants to take advantage of information asymmetry to 'gold-plate' services – increasing both the volume and cost of testing and treatments;
- lead to a perverse, self-reinforcing cycle: those players who are most efficient at implementing the incentives/consultant 'lock in' can increase profit margins to afford even greater incentives and ultimately create dominant positions; and
- impact customers adversely (by themselves or in combination with other features) through higher treatment costs/premiums and risks from over-testing/treatment.

1.2 These impacts are widely recognised in literature and in the US, have necessitated extensive areas of legal regulation. We cite as examples:

- A study published in one of the foremost US medical journal into the effects on treatment. See 'Association between Physician Billing and Cardiac Stress Testing Patterns following Coronary Revascularization' – Journal of the American Medical Association (JAMA – the US equivalent of the British Medical Journal (BMJ)) November 9, 2011 - Volume 306, No,18. The study concluded that 'Physicians who billed for both technical and professional components of nuclear and echocardiographic stress imaging studies were significantly more likely to perform such tests compared with those not billing for any component of the test. We consider there is much scope for manipulation, in particular where a test is simple and harmless or where the use of the treatment is one where a degree of discretion or judgment is needed'.
- The Stark Law: In the US it has been necessary to legislate heavily and over many years in this area to prevent physician self-referrals – that is, the referral of patients for designated health services that may be paid for by state healthcare plans to any entity with which the referring physician has a financial interest or relationship. In conjunction with the Stark Law, the Anti-Kickback Statute prohibits kickbacks, bribes, inducements, rewards, and other economic incentives and remuneration that induce physicians to refer patients for services or recommend purchase of medical supplies that will be reimbursable under government-funded healthcare programmes.

Both of these areas are discussed further below.

1.3 In the UK the adverse impact on patients is recognised in GMC guidance concerning financial arrangements and conflicts of interests. However the aim of the GMC guidance is primarily to prevent medical malpractice, rather than to act as an economic regulator.

1.4 Whilst the GMC guidance states that incentives should not be accepted by doctors, conversely the BMA has said that such practice is now endemic: "It should be noted, however, that indirect incentives such as free or discounted consultation rooms and

free or discounted administrative staff, are widespread in the market". Source: BMA Initial submission dated 21 May 2012, p4.

- 1.5 Since the incentives are contrary to GMC guidance, X, consultants have been reluctant to discuss these arrangements with us. However, we set out below a summary of the relevant examples of which we do have evidence.
- 1.6 AXA PPP understands that several hospital operators have represented to the CC that such arrangements have been modified or stopped, during the course of the OFT and CC's focus on the private healthcare market. AXA PPP believes strongly that such arrangements should be prohibited altogether, and that absent concerted regulation in this area, X.
- 1.7 Lastly we make recommendations on areas for further investigation and potential areas of remedy.

2 X

- 2.1 We summarise below several different types of arrangement that we have been made aware of. AXA PPP contends that, however structured, these agreements are designed to achieve the same consultant 'lock in' and that there is substantial value to the hospital operators in securing exclusive referrals of patients from 'tied' consultants.

Cash payments for diagnostic tests – X

- 2.2 AXA PPP performed an investigation into the activity of the largest private UK-based laboratory providing pathology services, X. This concerns, for example, X specialist whose profile of tests appeared to us to be excessive. X confirmed to us that he received a commission from X .
- 2.3 Further, we met with X of X in the UK, who told us that he was conducting an investigation into commission payments being paid for the use of X facilities. He confirmed the existence of X schemes, some of which he said were small and some were substantial; he described these as being "large enough to pay private school fees".
- 2.4 We obtained confirmation from X that the amount of charge paid by X to them for 'administrative charges' was X. X

Schemes to use hospital facilities

- 2.5** AXA PPP obtained details of a ✂ incentive scheme letter entitled 'consultant profit share' offered by the ✂ hospital group. ✂
- 2.6** AXA PPP highlights the very significant potential monetary value of these arrangements in relation to an annual consultant salary in the NHS of around £120,000. In the scheme offered to ✂ it also offered flexibility for a range of benefits ✂
- 2.7** Under a heading 'Benefit maximisation' it requests that consultants 'work with us... to achieve mutually beneficial targets'. It says that benefit can be maximised in two ways, both related to increasing revenues: by growing their individual activity to rise up the tiering scale and also by growing activity as a proportion of the total revenue pot.
- 2.8** We would also highlight that in our experience, and in contrast to practice within the NHS, providers of diagnostic pathology design the forms which are used by consultants to order tests in such a way as to maximise revenue for small incremental cost. For example they are commonly structured to include multiple tests as a 'default' in the first instance, such that single tests are harder, or even impossible, to order in isolation.
- 2.9** In January 2012, following a complaint from a member who had been treated at a ✂ hospital, regarding using up their entire outpatient allowance in a single visit, an investigation was launched. We wrote to the specialist asking if all the tests were ordered by him and the justification for them. The specialist replied that whilst most investigations were ordered by him, not all were. He stated that the pathology request form meant that each box he ticked ordered several tests some of which he would not have ordered given the choice (✂). As a result of this we approached ✂ to discuss this and as a result they agreed to implement a new pathology form which at least enables the consultant to pick only those tests that the patient requires.
- 2.10** As noted above, whilst the above arrangements take several forms we believe they act similarly to restrict competition, increase the number of, and costs per, treatment and serve to drive a perverse circle of reinforcement. Further, we believe that any current abeyance in this practice is 'coincidental' to the CC's investigation, and that strong action is required to remove such arrangements altogether.
- 3** ✂
- 3.1** AXA PPP submits that ✂ has taken the above types of arrangement a step further with a variety of other structures which serve to achieve the same outcome.
- 3.2** ✂

3.3 ✂

3.4 ✂

3.5 In May 2011 AXA PPP met and discussed the use of incentives with ✂ who have specific responsibility for development of consultant relationships ✂. They confirmed to us the existence of ✂ main types of arrangement and outlined how they work ✂ :

- ✂

-

- ✂

- ✂

3.6 AXA PPP believes the most commonly used type of agreement is the ✂ under which ✂ provides property and related services in return for the consultant referring patients to ✂ facilities.

3.7 AXA PPP believes this initiative comprises a substantial and widespread activity in ✂ at very significant cost to ✂ with ✂ having acquired some ✂ premises in the prestigious ✂. It is difficult for us to assess how many consultants are covered by this arrangement or what the precise arrangement is in each case, but it is common for these premises to accommodate 5-10 consultants each. ✂ We do not believe that ✂ would pursue such an expensive strategy unless it believes it will reap the benefits of related and greater financial returns from the consultants.

3.8 ✂

✂

3.9 ✂

.

3.10 ✂.

3.11 The impacts of the change of referral patterns following a consultant entering such a contract and the adverse impact on a competitor hospital are discussed further below in the case studies of ✂ (see section 4 below) and the ✂.

Increasing both volume and cost of treatments

- 3.12 It is our understanding that in many cases pathology tests are ordered from hospitals which are then submitted to the insurer as part of an invoice from the outpatient facility being run by the consultant in question. It is our view that it would be wholly wrong for a consultant to receive a direct payment from the provider of the pathology services as for example in the case of above. However have simply refined that model, such that the consultant is incentivised in exactly the same way. In this case the payment is made in the form of an additional mark up on an invoice presented to us by an outpatient facility, whose existence is dependent on the financial support of.
- 3.13 Clearly we also have direct contracting arrangements with for the provision of pathology services. It is impossible for us to believe that would facilitate the charging for these pathology services by these outpatient facilities (which it is), in a way which would be financially disadvantageous for it, compared with its direct contracts with AXA PPP. Indeed we would expect the opposite to be the case. In particular these arrangements guarantee the flow of business and motivate additional testing.
- 3.14 Further, a consultant surgeon, , has represented to us that he has a profit share arrangement for use of facilities at the hospital. He has reported to us that such arrangements are common and unlike himself many specialists do not declare this relationship to patients. In our view profit share arrangements are an inducement designed to promote usage, revenue maximisation and limit competition.
- 3.15 AXA PPP also submits as an example of incentives leading to excessive charging the case study of , referred to below in connection with additional services provided by relating to a billing agency focused on maximising consultant revenues, in particular from exploiting insurer processes.
- 3.16 AXA PPP identified a consultant, because of its concern over high charges: his cost per patient had increased by . He initially agreed to cooperate, but then declined to provide confirmation of what he had told AXA PPP's investigator. Nevertheless he said that his practice met with the billing agency and took their advice to increase their charges. He told us the way this works is as follows:

Perverse circle of reinforcement

3.17

The relevant GMC guidance which remains currently extant is set out below. We note that this guidance was revised recently on 25 March 2013 to become effective from 22 April 2013, AXA PPP contends that the main substance of the guidance has certainly not strengthened, and has arguably weakened this area of guidance, as explained further below.

*“You must act in your patients’ best interest when making referrals and when providing or arranging treatment or care. **You must not ask for or accept any inducement, gift or hospitality which may affect or be seen to affect the way you prescribe for, treat or refer patients.** You must not offer such inducements to colleagues”¹⁴*

*“If you have financial or commercial interests in an organisation to which you refer a patient for treatment or investigation, **you must tell the patient about your interest.** When treating NHS patients you must also tell the healthcare purchaser”*

3.18 AXA PPP strongly contends that the \times de facto constitutes an inducement which affects referral patterns and volumes, foreclosing competitors and distorting competition, and also that these agreements have not been visible, nor appropriately disclosed, to patients or ourselves.

3.19 In respect of the abovementioned changes to the GMC guidance, AXA PPP believes that the new guidance is, if anything, something of a dilution of the previous position. See http://www.gmc-uk.org/guidance/news_consultation/20477.asp. This emphasises our view that the GMC is not in a position to address these competition issues.

3.20 \times

3.21 \times

Additional administration and support services

3.22 AXA PPP has highlighted previously that in some of the \times acts to introduce consultant practice services with a view to increasing revenues from insurers. AXA PPP considers that this evidences:

- their focus on maximising revenues;
- their interest to attract and tie in consultants; and
- provides further means by which \times can supply services, the financial structure of which allows \times to make payments ‘in kind’, in return for referrals they expect to receive from the consultant practice.

3.23 X. We also supplied background to a billing company called X which X introduces consultants to and as above, sometimes pays for on their behalf. This company markets itself as being able to maximise revenues for consultants through its knowledge of insurer processes and charges its own fee as a percentage of the amount invoiced. The fee normally charged is 5% of amounts invoiced. X advertises that it can increase fees by 25% after its fee of 5%. We highlight that such coding advice can also increase hospital fees as these are also dependent on the nature of the treatment reported to us by the consultant.

3.24 In X to the same submission AXA PPP provided a copy of a brochure advertising the services of X, which is a wholly owned subsidiary of X and provides services to consultant practices, including the introduction to X.

3.25 We believe that the substance of these arrangements, no matter the form they take, is to confer significant economic benefit to the consultants in return for ensuring even greater returns from the consultants in the 'tied' supply of hospital patients and therefore substantial revenues.

3.26 We believe the arrangements are structured this way to avoid direct payment, but as noted above, are tantamount to the same thing. We highlight that X demands X.

X

3.27 For larger types of arrangement X has established a number of X, which appear to be more suited to segments of the market where X wishes to:

- engage with larger groups of consultants, for example in relation to a X;
- X

3.28 X X

3.29 X

3.30 X

3.31 X

-
-

3.32 X

3.33 X

-
-

-
-

3.34 ✕

3.35 These entities appear to give profit-sharing potential to individual consultants as members, in a tax advantageous way, whilst the business risk (provision of assets and operational funding) is borne by ✕.

3.36 As to entering into and disclosure of financial interest, the non-adherence with the GMC guidance referred to further above also appears evident; the partners who are also practising consultants appear to have a financial interest in the profitability of these businesses and the equipment being operated therein. AXA PPP expects those consultants and organisations to make relevant disclosure concerning the nature of their referral arrangements with the ✕ other hospital interests.

3.37 ✕

3.38 AXA PPP has provided previously an investigation into the practice of a prominent consultant ✕. We demonstrated some of his financial interests (as a designated member of ✕.

3.39 We submit that, as for ✕ the effect of each of these types of ✕ no matter how they are structured, is to confer substantial economic benefit to the consultants in return for ensuring the supply of hospital patients and therefore revenues (both through increased volumes and revenue per patient), from which in turn, such inducements can be afforded.

4 Adverse impacts on the consumer

4.1 As noted above in Section 1 we believe that the impact of consultant incentives is to restrict fair competition for patients by creating exclusive/'tied' arrangements which distort the patient journey, exclude competitors and create barriers for new entrants;

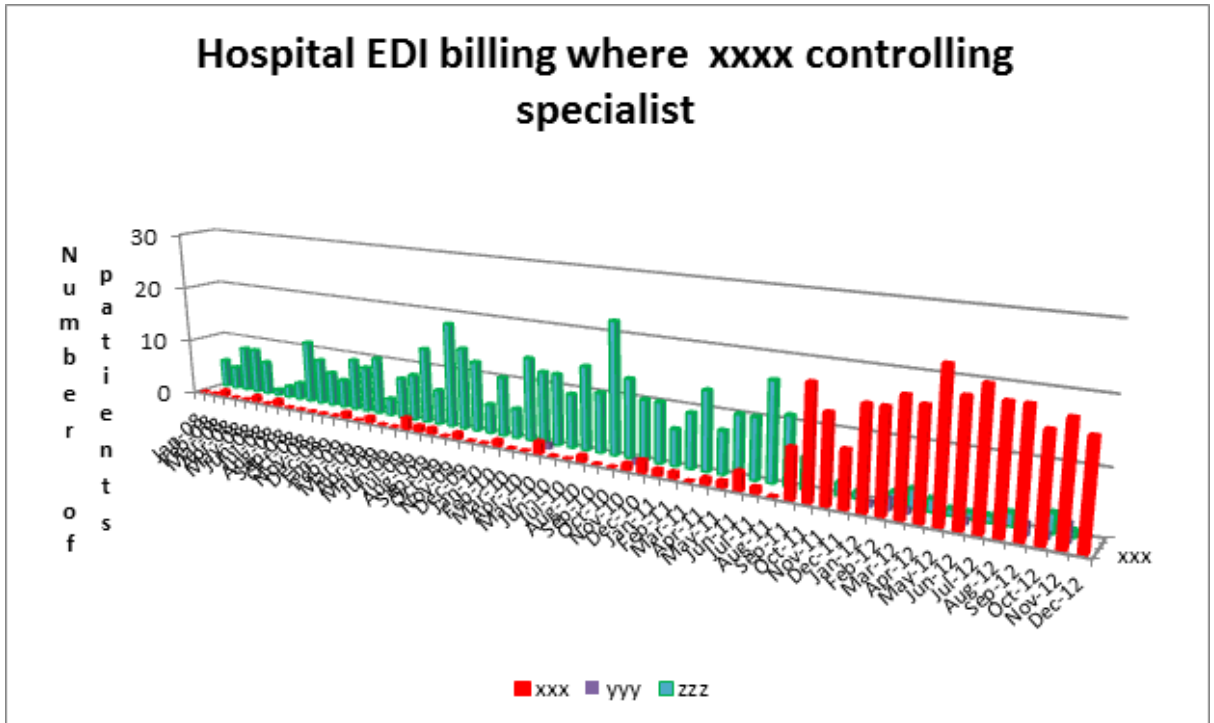
4.2 In addition we contend that they motivate consultants to exploit information asymmetry to 'gold-plate' services – by increasing both the volume and cost of treatments to an unnecessary degree.

4.3 Thirdly, they lead to a perverse self-reinforcing cycle: those players who are most efficient at implementing the incentives/consultant 'lock in' can increase profit margins to afford even greater incentives and ultimately create dominant positions.

4.4 AXA PPP discusses evidence of each of these areas below.

Referral pattern

Set out below is a graph of the number of patients referred by a single specialist to HCA hospitals following the start of a fully managed contract. This shows immediate and almost complete referral away from the X in favour of Y.



4.5 AXA PPP has outlined previously discussions held with two representatives from the X. This was X a new private unit. AXA PPP showed a graph of hospital admissions comparing those of the X against those of the Y, showing a reduction in admissions to the X with an increase in those to the Y at a time when increased capacity at the X might normally be expected to have increased.

Referral against wishes of patients

4.6 AXA PPP has provided previously, as transcripts of telephone conversations with three X patients of a prominent consultant, X evidence that they were each directed by him, for apparently spurious reason and against their preference, to the X hospital in X, as opposed to their more local X hospital in X. X

4.7 X X

4.8 All of the above should be taken in the context of the following. A typical blood profile test will cost £5-10, and generate an invoice of X or more to an insurer. By adding an additional element to the testing profile, the marginal cost will be around 10 pence and the marginal additional revenue can be X. Given that these test are so common – and occur for a very high proportion of all inpatient and day case admissions, as well as a significant proportion of outpatient cases, the revenue generation potential is obvious.

Overtreatment

4.9 X

4.10 In AXA PPP's response to the X submission, we provided reference to research on this topic, which is all the more likely for less invasive tests such as blood tests. The research we referenced, and which was published in one of the foremost medical journals in the US, determined that for stress echocardiography the increasing likelihood of tests being ordered was 7.1 times more likely if the doctor also charged for interpretation and 12.8 times more likely if the doctor charged for the facility as well.

4.11 This large-scale study was undertaken in the United States comprising 18,000 patients with the insurer United Health. It showed a clear (and vast) increase in the incidence of tests being ordered compared to the baseline (where the doctor has no interest at all). We consider that it would be naive to assume that British consultants, compared to their American counterparts, are not economic actors that respond, even subconsciously, to clear economic incentives.

4.12 As noted above the X agreements we have noted in the UK provide lucrative potential benefits for referral and for increased revenues and high margins on large volumes of pathology testing.

5 Scale of HCA activity

5.1 As noted in HCA's submission dated 31 July 2012 it listed eleven outpatient and diagnostic centres, which provide outpatient consultation, diagnostics, and private GP facilities in and around London. These comprise:

30 Devonshire Street

31 Old Broad Street
 Brentwood Medical Centre
 Chelsea Outpatient Centre
 City of London Medical Centre
 Docklands Healthcare
 The Harley Street Clinic Diagnostic Centre
 The New Malden Diagnostic Centre
 Platinum Medical Centre
 Sevenoaks Medical Centre
 Wellington Diagnostics and Outpatients Centre, Golders Green.

- 5.2** In addition, HCA has been acquiring significant other primary care interests in London, notably, the Roodlane Medical Group, Blossoms Healthcare and GenMed (10 GP practices operating as Medicentres).
- 5.3** Also it has entered into two very significant joint venture arrangements with LOC partnerships and Robotic Radiosurgery LLP.
- 5.4** with
- 5.5** All of this is in addition to its ownership of 6 of the 7 must have elite private hospitals in central London.
- 5.6** Taken together, we submit that with has clearly made very large investments in addition to its hospital ownership. We believe this can only be based on strong commercial logic and would suggest that this would consist of:
- o protection of its already dominant position in the central London hospital market
 - o sustaining its ability to with
 - o maximising the flow of patients into its facilities; and
 - o maximising the revenue from each patient seen in its facilities.

- 5.7 We believe this is to the detriment of competition in London and ultimately the consumer.

6 Recommendations

- 6.1 AXA PPP strongly urges the CC to assess fully the nature, prevalence and impact of incentives paid by hospitals to consultants to assess their effect on market competition and increased cost, in particular in London ✂. AXA PPP believes there is evidence of widespread use that is likely to become even more extreme if this is not addressed and arrested as part of the CC investigation.

- 6.2 In order to pursue this AXA PPP recommends that the CC seeks to obtain full details of the relevant agreements/arrangements and their economic impact, no matter how they are financially structured, with:

- 6.3 ✂ In addition we would recommend that the CC considers the impact on competition of these 'tied' arrangements, by:

✂

- 6.4 Faced with same situation, the US government has implemented extensive regulatory safeguards as described below. AXA PPP contends that similar action is required in the UK ✂

- 6.5 In the US, federal laws prohibit or restrict the referral of government-funded healthcare by doctors who have a financial interest. The Anti-Kickback Statute was enacted to protect patients and federally-sponsored healthcare programmes from fraud and abuse by curtailing the corrupting influence of money on healthcare decisions. The primary purpose of the statute is to prevent kick-backs or payoffs to those who can influence healthcare decisions. With some exceptions, the statute prohibits kickbacks, bribes, inducements, rewards, and other economic incentives and remuneration that induce physicians to refer patients for services or recommend purchase of medical supplies that will be reimbursable under government-funded healthcare programmes. Both sides of the kickback relationship are liable under the statute.

- 6.6 As noted further above, the Stark Law was enacted to prevent physician self-referrals – being the referral of patients for designated health services that may be paid for by state healthcare plans to any entity with which the referring physician has a financial interest or relationship. Although it is a separate statute, the Stark Law complements the Anti-Kickback Statute – the Stark Law and the Anti-Kickback Statute refer to one another, and make compliance with one a requirement of complying with the other. Both are intended to prevent healthcare providers from taking actions for the purpose of financial benefit to themselves instead of for the patient's benefit. Through whistle bower lawsuits, private individuals have recovered substantial sums of money from healthcare providers who have violated the Anti-Kickback Statute. Source: <http://www.bernlieb.com/whistleblowers/Anti-Kickback-Statute/index.html> AXA

- 6.7 In addition under the Patient Protection and Affordable Care Act, no physician-owned hospitals may start or expand after the deadline of 31 December 2010. This was further upheld in a recent legal challenge. See: http://www.azhha.org/member_and_media_resources/documents/FindingYourWayvol1no7Physician-ownedhospitals.pdf

- 6.8 ✂

6.9 We would therefore recommend that the CC gives serious consideration in respect of potential remedies to:

- ✂
- Wide-reaching regulation to ban incentives in the UK, building on the learning of practices in the US, as discussed above.

✂