

## PRIVATE HEALTHCARE MARKET INVESTIGATION

### Summary of hearing with AXA PPP held on 8 October 2013

#### Introductory comments

1. AXA PPP (AXA) considered that the issue facing the private healthcare industry was that there were a number of areas where specific hospital groups had strong local concentration, and had put in place arrangements which were designed to exploit, defend and extend that market power. These arrangements were usually in the form of incentive schemes, but increasingly in the form of equity partnerships and ownership arrangements.
2. AXA believed that the effect of these incentive arrangements was to prevent competition, limit the number of new entrants coming into the market, to achieve 'must-have' status with PMIs, to increase prices, to ensure that there was more treatment than there otherwise would be and to subvert the patient and consultant relationship.

#### Central London—divestments

3. Ideally there needed to be a minimum of three suppliers of private hospital services in central London. It considered that the range of specialities of the hospital should be taken into account in relation to any proposed divestments.
4. AXA would be concerned if HCA were to remain too powerful in a particular specialism and it also had residual concerns about the effect of its vertical integration strategies (eg subsidiaries of HCA which employ groups of consultants). This was because even if the CC were able to change the ownership of HCA's hospitals, HCA might still be able to control the flow of business to particular hospital operators.
5. There would be a lot of buyers interested in acquiring HCA facilities if any were to be divested in central London. AXA did not consider it appropriate for HCA facilities to be divested to providers that already had a significant presence in the market. There was likely to be interest from existing operators as well as new entrants to the market.

#### Outside central London—divestments

6. The competition issues facing the industry outside central London were less severe than the competition problems within central London. It was preferable to have three hospital operators in each local area. However, given the size of many towns in the UK, only one NHS hospital might be required and there might not be enough patients to justify more than one private hospital.
7. Divestments would be appropriate in regions where there were three or four hospitals owned by the same hospital operator, with no alternative facilities nearby. Divestment would be an effective remedy outside central London where it would lead to more viable competitors within a geographical area.
8. Not only the location of the hospital, but whether it was a 'must-have' from the perspective of corporate customers, would be relevant in identifying which hospitals would be effective divestments.

9. There would be suitable purchasers for possible divestments outside central London, including both new entrants and existing operators. AXA suggested that there might also be some US-based operators who could be interested in entering the UK market.

### **Procurement arrangements for prescribed lists of tests**

10. AXA proposed an additional remedy, namely, developing a prescribed list of tests where PMIs would have the right to make their own procurement arrangements. This remedy might enhance competition for a significant amount of hospital activity where divestment may not be a plausible remedy.
11. A significant amount of a hospital's activity involved conducting tests and scans. This was where the hospital operators' excess profits exist. Even in solus areas, there should be competition for the provision of such services which currently did not occur as the services were purchased through the solus providers. AXA could send a courier around twice a day to pick up blood samples etc and have them tested elsewhere by a third party and returned to the hospital the next day. AXA could in some cases be able to reduce the price it was charged for these tests by up to [✂] per cent.
12. AXA was prevented from implementing a strategy like this at the moment since the hospitals had a monopoly of the operating theatres and beds. A limitation of this remedy might be where tests needed to be completed urgently. However, tests such as blood tests could often be completed and returned overnight. The price of scans and tests in central London were highest and where super profits occurred, and this was being driven by the use of incentives to encourage the carrying out of extra tests.

### **Tying and bundling**

13. AXA did not consider that tying and bundling should be banned completely. It understood that the purpose of this remedy was to prevent it acting as a barrier to new entry and considered that it should therefore only apply to areas where this was in fact a new entrant. AXA was, however, in favour of a ban on the use of 'one-in, all in' style arrangements between PMIs and hospital operators.

### **Restrictions on expansion in solus and duopoly areas**

14. AXA was in support of the proposed remedy of restricting the expansion by private hospital operators in solus and duopoly areas into the operation of private patient units (PPUs). However, there needed to be greater clarity of what the role of the OFT and Monitor would be in monitoring and enforcing these issues. When a PPU was being put out for tender, it should be scrutinized on the basis of what it would do to local competition, including local private hospital competition. NHS trusts would be capable of running PPU units.
15. Restrictions on the expansion by hospital operators into the operation of PPUs should be applied on a local basis. AXA did not consider this to be a national issue and should not be applied more broadly to those hospital groups which might have been found to have some degree of national market power. It would object to a hospital operator taking over a PPU close to a hospital which had a degree of market power in its local area. It considered that this should be looked at on a case by case basis. Expansions by hospital operators into the operation of PPUs should be considered under the merger regime.

## **Consultant incentives**

16. AXA was in favour of a complete ban on the payment of incentives which had a financial effect on consultants. It had a real concern that consultants might be putting themselves forward as being independent, but were receiving incentives from hospital operators. It would be different if a hospital operator owned and clearly stated that it owned a GP practice and everybody understood that it referred patients to its own hospitals, because such arrangements had been disclosed.
17. AXA did not consider that the current protections afforded by the General Medical Council (GMC) and the Bribery Act adequately addressed consultant incentives. The GMC was not constituted and set up to police these types of issues, as it focused on medical negligence. The standard of proof required for the GMC to sanction or remove a doctor was at criminal levels of negligence. AXA did not think that the GMC would take on a role of an economic regulator and suggested that this type of economic regulation might fall within Monitor's role.
18. AXA considered that compulsory registration of consultants' financial interests might be beneficial. However, it would not of itself be sufficient to address these issues, as it did not take away what incentives do. Incentives actually changed consultant behaviour, which was the purpose of hospital groups offering them.
19. AXA was not opposed to a new entrant discussing with existing doctors in an area how the consultant might view a new facility and whether the consultant expected they might use it, but was opposed to a new entrant building the facility and offering an equity stake to the consultant in return for referrals. AXA also considered it inappropriate for hospital operators to incentivize doctors to use a particular scanner, equipment or to carry out particular tests based on profit-share arrangements. It was concerned about the relationship between incentives and doctors' treatment decisions.
20. In terms of how any existing incentive schemes should be unwound if this was pursued by the CC, the payment of financial incentives could be simply unwound by requiring hospital operators to stop paying incentives. In terms of equity stakes, there would need to be certain mechanisms in place in order for these to be unwound over time. There should be an outright ban on allowing consultants to refer patients to hospitals in which they had an equity stake, or any financial incentive. AXA would also be against donations to organizations which could be a means of hiding where payments were actually going.
21. Where an outright and indefinite ban in respect of equity stakes was determined by the CC to be disproportionate, it might be appropriate for such ban to have a two- to three-year review period so that it might be assessed whether any prohibition on incentives had the effect of deterring new entry and could be scaled back accordingly. Any ban on the payment of incentives could be monitored by hospital operators and/or they could be required to report to an industry body such as the GMC that they did not give or receive any financial incentives, or have any financial interests. A body like Monitor could be responsible for enforcing these issues.

## **Consultant groups**

22. AXA did not agree with the conclusion in the CC's provisional findings to the effect that the operation of consultant groups did not raise competition concerns. In AXA's experience, the singular purpose of consultant groups, such as anaesthetist groups, was to generate more economic power in order to push up prices.

23. Research undertaken by the CC showed that there had been increases in prices when consultant groups had come together. AXA provided an example of [X], where [X] out of [X] anaesthetists practising in that locality were part of the one anaesthetist group, and all charged the same price for their services. It was difficult to see how this would not have an adverse effect on competition (AEC), as the group restricted price-based competition in that market.
24. AXA did not consider that every consultant group would give rise to an AEC, but would be concerned about any groups which comprised the bulk of the specialists in a particular field in a particular locality who all set the same price for their services. AXA was concerned that the CC's provisional findings might suggest to consultants that there was nothing wrong with setting up these types of partnerships, regardless of what they were doing, and that unchecked they would become more prevalent.

### **Information on consultant performance and fees**

25. AXA had some concerns about the CC's proposed remedies concerning consultant performance. It would be concerned if there was an attempt to rank the performance of consultants based on data, as it might not be meaningful, and there would be an impression of spurious accuracy around what was published. AXA was not opposed to the principle of providing some metrics around consultant quality, but was concerned about whether this would be achievable and would achieve its intended aims. Consultants appearing in the top proportion of any quality rankings may view this as a reason for actually increasing their prices.
26. AXA considered it a possibility that having more information available about consultant fees could lead to higher prices. It agreed that consultants should be required to disclose prices to patients prior to treatment.
27. AXA expressed some reservations about whether the introduction of ICD-10 coding would provide an effective means of monitoring overtreatment by consultants. In its view, ICD-10 coding was not very reliable and it was sceptical about the costs and resources required to transition to IDC-10 coding and the usefulness of the data which would be obtained. AXA did not consider that the use of ICD-10 coding would be more accurate and effective in identifying where a consultant might have over-treated or overtested a patient. This was because it gave information about the condition but would not give information about the level of complexity within that.
28. The PHIN project was well intentioned but AXA expressed a degree of unease as to whether it would achieve what it was looking for. The industry should encourage the collection of PROMs-style data for the private healthcare system, but AXA was not convinced that this data could be effectively used to differentiate between the performance of individual consultants and hospitals. Rather it might tell the industry more about outcomes overall for particular treatments.