COMPETITION COMMISSION

PRIVATE HEALTHCARE MARKET INVESTIGATION

Summary of hearing with Nuffield held on 27 September 2013

Divestment remedies—outside of London

1. Nuffield was broadly supportive of the Competition Commission's (CC's) idea of the divestment of certain 'cluster' hospitals in regional areas, however, it believed that there were still some assets that were classified as 'must-have', and if the CC did not address these assets, the divestment might not go as far as it needed to. The CC's remedies were all interlinked and one was supported by the others.

2. Nuffield considered that divestment of the identified cluster hospitals would open up the market for self-pay patients, however, this remedy would not deal with national issues resulting from the bargaining power held by hospital operators with 'must-have' hospitals in multiple solus or duopoly markets across the UK. For insured patients, the effectiveness of divestment would depend upon the issue of tying and bundling and the amount of leverage available.

3. Nuffield told us that market scale and local market concentration must be considered alongside the importance of a geographic market to private medical insurers (PMIs). The CC remedies needed to pay greater attention to the importance of different geographic markets.

4. PMIs required coverage across all of the UK's corporate hotspots in order to have a credible offering to large business. Nuffield maintained that 'must have' hospitals and their concentration with particular hospital operators had a greater distorting effect on the market than the scale of any operator. Operators with a stronghold in too many strategic corporate markets had a disproportionate power in insurer negotiations. Therefore divestment of certain 'cluster' hospitals in the regional areas identified would not on its own be enough to remedy the current market distortions identified by the CC.

5. With regards to solus or duopoly areas Nuffield told us that if one private health provider had a significant number of 'must-have' hospitals in the right markets, then the combination of local market power in different local areas would increase its bargaining power in negotiating with insurance companies. Nuffield believed that such 'must-have' hospitals were related because if an insurer did not have those hospitals on its network, it could not offer a corporate product.

6. Transferring a hospital, in a solus or duopoly area, from one owner to another could reduce the overall market power not only regionally but nationally. If it coincided with a strategic insurer market it could therefore lead to downward pressure on prices. As long as this reduced the overall number of hospitals a provider held nationally in strategic corporate markets.

7. There were a number of main players, Nuffield included, who would be interested in purchasing hospitals that were divested as a result of the CC's findings. Nuffield was aware of private equity investment and foreign hospitals operators who were interested in entering the UK hospital market.

Divestment of private patient units

8. Divestment of private patient units (PPUs) would not have an impact on the competitive structure of the market.

Divestment—central London

9. Nuffield believed that if HCA divested two of its competing London hospitals this would be sufficient to change the competitive nature of the market and offer PMIs much more choice. The hospitals should also be sold to different organizations.

10. Nuffield told us that should any of HCA's hospitals in London be divested, it would be unsuitable to divest to an operator which had too many must-have hospitals. Reasonable constraints would also need to be put in place on any of the existing operators which acquired one of the two hospitals, to prevent them from bundling and leveraging those assets. Nuffield would be concerned about 'asset swapping' because this would simply involve swapping one bit of power for another. This was connected to Nuffield's concern about operators owning hospitals in too many strategic corporate markets holding disproportionate power in insurer negotiations.

11. Nuffield was against consultant incentives and would support any move to ban all incentives which would over time help dissolve the problem of consultant drag. PMIs were slowly moving towards directional products, but it would take about five years to make the switch. This in turn led Nuffield to believe that there were potential problems for any potential purchaser of either of the HCA London hospitals. Nuffield wanted to compete on price and quality for consultants, without having exclusive deals with consultants. This was in the interest of the consumer. Nuffield also had concerns regarding obtaining referrals from GPs (in the case of self-pay patients) and PMIs and being able to direct or encourage consultants to take on the referrals in its hospital.

Tying and bundling

12. The issue of tying and bundling was that those operators that had hospitals in too many strategic corporate markets were able to leverage their portfolios to increase prices to PMIs. It resulted in a 'one in, all in' argument for the hospitals and other hospital groups effectively ended up excluded by PMIs from their networks.

13. The CC had proposed two remedies regarding hospital negotiations with PMIs. The first required that volume discounts should be offered at hospital level and not at group level. The second would require each hospital to negotiate separately with the PMI. Nuffield had concerns with these proposed remedies, believing that both could be circumvented. Pricing hospitals individually could lead to some hospitals being priced in such a way as to make up for the smaller prices in others. They would effectively be disproportionately expensive, particularly in areas where there was no alternative competition.

14. With 80 per cent of the market being controlled by two PMIs, if these PMIs decided to direct their work to specific hospitals, the excluded hospitals would suffer severe consequences. Although it was not in the PMIs' interests to drive the smaller hospitals out of business, the situation as it was could lead to an unintended consequence and could be harmful to the consumer.

Private patient units—expansion proposals

15. Most foundation trust teaching hospitals were looking to open PPUs and Nuffield believed this was an area that would continue to grow. At the moment, PPUs did not offer a significant competitive constraint but in the future they would be a major part of the industry.

16. Nuffield had slight concerns about PPUs operating with a state subsidy since that could lead to a distortion in the market. Consultants might feel more comfortable treating Intensive Therapy Unit patients at a Trust site in a PPU facility and might therefore start to move all their secondary work away from a private hospital. This could lead back to there being one player in some markets since the remaining asset could not invest because the market might not be big enough.

Incentives

17. Nuffield was in favour of a complete ban on consultant incentives and did not see any reason why it would be in the interest of the industry to allow new entrants to offer such schemes. The ban should be broad and fall across the whole of the healthcare industry including both self-pay and insured patients. This would require a fair market price test, by a regulatory or professional body, to ensure that the ban was being applied.

18. Nuffield was also against equity arrangements and believed they should be dis-continued and existing ones unwound over a period of time.

19. Nuffield did not foresee hospital operators experiencing problems in attracting consultants to practice at their hospitals once the ban was in place. Hospitals could compete via quality, service offering, equipment and good customer service. Part of the reason why incentives were becoming more common had been that incumbent hospital operators were offering incentives to consultants to stay at their hospital, to block the new entrant from accessing consultants. Although it might not be easy to persuade consultants to move hospitals—for example, if they had been practising at a hospital for over 30 years they might not wish to move—there was an equal chance that a consultant might be unhappy and welcome the chance to switch hospitals.

Consultant quality information

20. Nuffield believed there should be absolute transparency of information for patients. It was important for the industry to come together and collect and publish data and The Private Healthcare Information Network (PHIN) was doing a useful job of publishing such data. Nuffield saw PHIN as an important part of the industry moving forward and thought it important that the industry was mandated to produce the correct quality data.

21. However, Nuffield was concerned about merely replicating the collection of NHS data. Nuffield highlighted that HES was under review and that the data provided must be based on customer insight to ensure that it was relevant to the needs of the consumer and provided in a non-technical format that was readily accessible to the consumer.

Information availability of consultant fees

22. Nuffield was in favour of consultants publishing their fees. It was concerned that if fee data was published without quality data alongside it, patients might assume that

higher prices meant better quality. Nuffield absolutely supported transparency around consultants' fees.