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25 April 2012,

Christiane Kent
Inquiry Manager
Private healthcare market investigation
Competition Commission
Victoria House
Southampton Row
London
WC1B 4AD

Re: Private Healthcare Market Investigation

Dear Sir/ Madam,

Thank you for your letter dated 4th of April 2012. Nuffield welcomes the opportunity to provide an initial submission summarising our position regarding the forthcoming investigation into the Private Healthcare (PH) market. We hope the views expressed in this letter will help the Competition Commission (CC) outline the theories of harm it intends to include in the Issues Statement.

Nuffield broadly agrees with the Office of Fair Trading's (OFT) assessment of the market and supported its referral to the CC. We agree that there are complex and interrelated features across the market that prevent, restrict or distort competition.

Further, we believe that many of these adverse features are historic, have beleaguered the market for years and, if unaddressed, will continue to have long lasting effects on both the market and consumers. We therefore fully encourage the CC to undertake a holistic analysis of the overall market to address its distortions and anti-competitive aspects.

As the largest independent trading healthcare charity in the UK,Nuffield seeks to provide the best quality healthcare to patients at competitive prices.Our group now operates 200 facilities including 31 hospitals as well as Clinics, Fitness and Wellbeing Centres, Corporate Wellbeing Centres and diagnostic units. We are a medium size Private Healthcare provider, and over time, the adverse features identified have noticeably impacted our position and strategy in the hospitals market. We are therefore in a good position to support the CC's investigation and look forward to evidencing this further.

Whilst it is our view that adverse features in the market that have emerged over a period of time do not always act in the interests of those funding and benefiting from private healthcare, it is also important to emphasise that the quality of private healthcare provision in the United Kingdom remains of a very high standard, although greater transparency along the patient journey is required.

I include as part of this letter an Executive Summary of the issues we believe indicate that the market is not operating effectively. This is followed by a more detailed overview of the principle arguments that sit behind these and the implications they have regarding the scope of the investigation. I hope this proves informative in framing your Issues Statement.

Under separate cover we have sent to you the Off the Shelf Information requested in your letter of 4 April 2012. Please note that much of the information contained in this letter and our Off the Shelf information submission is confidential and commercially sensitive and is sent to you for your sole use in carrying out your investigation subject to the conditions that:-

(i) it is not disclosed to any third parties; and

(ii) it is not made public either directly or indirectly without the express written consent of Nuffield Health; and

(ii) it is used only by the Competition Commission for the purposes of its Private Healthcare Market Investigation.

Should you wish to discuss any aspect of our submission, require further information, or wish to visit one of our Hospitals please contact me directly with any questions you may have. We look forward to working with you as the investigation progresses over the coming months.

Yours faithfully,

David Mobbs

Group Chief Executive

Executive Summary

The OFT identified features in the Private Healthcare market which prevent, restrict or distort competition in the UK. Although Nuffield broadly agrees with the OFT's view of the market, we do believe that in a number of areas it has based its conclusions on a superficial understanding of the level complexity and interrelation between market features.

We believe that a successful CC investigation will require an in-depth understanding of the market and its complexities. We have therefore included in this initial submission an overview of the key issues and dynamics of the market we perceive, and why, in our opinion these have an adverse effect on competition.

We hope that the CC's investigation will be more in depth, and go a lot further in terms of remedies than those suggested by the OFT, if it is to address the structural flaws that have stifled competition for years.

As such, we take the opportunity within this submission to highlight the shortcomings in the OFT's analysis and illustrate areas where the CC will need to undertake robust analysis to go beyond the OFT's position.

Following the general structure of the OFT's review, the table below summarises Nuffield's position on the key issues identified as affecting competition in the market. These include a number of issues overlooked by the OFT, that we deem key to the investigation. The detailed explanations and arguments behind our position(s) can be found in the main body of the document that follows. We will then summarise the issues that were not addressed as part of the OFT's review that, we believe, should form part of the CC's scope of investigation going forward.

		OFT Position	Nuffield's Position
1. Information Asymmetries	PH Quality	• Lack of information available to GPs, PMIs, patients • Need for providers to publish clear, accessible and comparable quality information	• Nuffield agrees with the OFT and supports the need for clear, transparent quality information; we believe this should go beyond Hellenic
	PH Price	• Lack of information available to GPs, PMIs, patients • Need for 'choice tool' for patients to compare self-pay prices	• Nuffield supports the need for price transparency in the market, but believes this should not be restricted to self-pay prices and must include prices charged for PMI patients

		OFT Position	Nuffield's Position
1. Information Asymmetries	Consultant Quality	• Lack of information available to GPs, PMIs, patients • Consultants should publish outcome and process measures to GPs, PMIs, PH providers	• Nuffield supports the need for consultant quality information • Given the importance of consultants, in our opinion, this is crucial for the consumer
	Consultant Price	• Lack of information available to GPs, PMIs, patients • Consultants should provide fee and shortfall estimates upfront	• Nuffield agrees that there is a lack of price information available and broadly agrees with the remedies put forward; though these should include both self-pay and PMI patient prices
2. Concentration of PH provision		• The market is concentrated at a national level • At a local level, there appear to be areas of high concentration that may convey a degree of market power	• The OFT has not fully or accurately defined the local and regional markets or fully understood the complex combination of factors that create concentration • PH concentration should be considered in the context of the adverse effects of PMI networks, which play out to the benefit of larger PH providers with strategic market advantages
2.i PPUs and Competitive neutrality		• Partnership agreements between PPUs and PH providers have the potential to alleviate concentration in local markets • Supports competitive neutrality but does not address this issue or the competitive constraint of PPUs in depth	• Nuffield agrees that PPUs may alleviate concentration in certain local markets • In our opinion, PPUs constitute a competitive constraint on PH providers. The proposal to raise the private work cap to 49% will exacerbate this further • As such, competitive neutrality of NHS PPUs is crucial and should be investigated further by the CC

		OFT Position	Nuffield's Position
3. Concentration of Consultants		• There is a high concentration of anaesthetists organised in Anaesthetist Groups (AGs) • OFT has left it to the CC to investigate the situation in regard to all Consultant Groups	• Consultant groups of all specialities are rapidly emerging, and creating consultant concentration at local, regional and national levels • The practice of these groups using their market power to leverage additional fees and/or incentives should be fully investigated
3.i Concentration of GPs		• N/A: not addressed	• GP groups also exist and, given the context of the NHS reforms, should be fully investigated so as to 'future proof' the industry
4. Barriers to Entry & Expansion	PMI Contracting	• Network recognition and associated consultant drag are significant barriers to entry • Suggests banning providers using price increases or other means to deter the recognition of new facilities on PMI networks	• We do not believe that networks in themselves are a barrier to competition, but that the exclusive nature of some networks combined with the market power of the largest PH providers and the resulting 'consultant drag' effects serves to adversely impact the market • Nuffield supports the OFT view that it is the combination of PMI networks, PH provider market power and 'consultant drag' that constitutes the crux of the competition issue in the Private Healthcare market • The influence of providers with market power on PMI networks may result in the exclusion of facilities that are of comparable quality but lower cost • This is a barrier not only for new entrants, but also for existing providers seeking to develop in new local markets • The remedies proposed will not solve the long term harm of networks on the market

		OFT Position	Nuffield's Position
4. Barriers to Entry & Expansion	Consultant Incentives	• Incentives paid directly or indirectly to consultants may discourage consultants from treating patients at new entrant facilities • All incentives should be transparent and banned for PH providers with market power	• Financial incentives operated by any PH provider create barriers to entry for both new entrants and existing providers seeking to develop in new local markets • Financial incentives prevent effective competition by 'artificially' raising the cost of care • All direct financial incentives to consultants should be banned and indirect incentives should be made transparent
	GP Incentives	• The emerging trend of providing financial incentives to GPs may develop as a barrier to entry	• Given the formation of GP groups, Primary Care Triage Centres and forms of horizontal integration in the market, GP incentives are likely to create barriers to entry • All financial incentives to GPs should be banned

Key issues and arguments

1. Information Asymmetries

Price and quality information asymmetries exist for both Private Health (PH) provision and Consultant services. The impact these information asymmetries have at various stages of the healthcare 'customer journey' are shown in Figure 1.a and Figure 1.b at the end of this section

a. Private Health Provider, Quality

The OFT concluded there is a shortage of accessible, standardised and comparable information provided to patients and their intermediaries in relation to the quality of PH facilities. This information asymmetry weakens the ability of patients and their intermediaries to drive efficiencies and stimulate competition between rival facilities. As a remedy, the OFT has suggested, building on the Hellenic project, to put in place a commitment by PH providers to publish clear, accessible and comparable quality information.

i. Nuffield's position

- Though Nuffield supports the development of Hellenic, it does not believe it constitutes the full solution to the information shortages consumers face
    - In our view, it represents only a portion of the information consumers or intermediaries require to make informed decisions
- In order to fully address this issue, the industry should create and publish quality metrics addressing the specific information needs of key stakeholders of the Private Health market (i.e. GPs, PMIs, patients)
    - The industry should not limit itself, or focus solely on, replicating the quality metrics of NHS choices
    - This information should be in a language and format that is readily accessible to all stakeholders

ii. Our key rationale behind this is the following:

- The lack of accessible and comparable information regarding the quality of PH facilities available to GPs, PMIs, and patients weakens the drive for efficiencies and competition between PH facilities
- The CC should not underestimate the quantity of quality data already available and the role and responsibility of PMI providers in unlocking this for the consumer's benefit
    - PMI providers hold a wealth of quality data on their network providers, generally acquired during procurement processes and through contract monitoring requirements

iii. Key considerations going forward:

- We hope that the CC will investigate how quality metrics beyond those of NHS choices would be beneficial to the consumer and intermediaries

- In order to assess the feasibility of such metrics, Nuffield is prepared to evidence the current quality data requirements we are regularly subject to through our PMI contracts, CQC registration, NHSLA, Information Security and other accreditations. Nuffield can also provide research it has commissioned in relation to how GPs and patients choose their private healthcare provider.

b. Private Health Provider, Price

As with quality information, the OFT concluded there is a shortage of available PH facility price information for patients and their intermediaries. In particular, it concluded that it is difficult for self-pay patients to easily compare prices charged by different PH facilities. As a remedy, the OFT suggests developing a 'choice tool' for private patients by which self-pay prices could be compared between facilities.

i. Nuffield's position

- We agree that there is a need for more accessible pricing information for GPs, patients, as well as PMI providers and corporate employers.
    - We believe that limiting price transparency to self-pay patients is restrictive, and that this should also extend to the charges made for the provision of services to PMI providers.
- Given the disparity in pricing methods across the market, the CC must investigate in detail the pricing comparison structure that should be used in order to compare prices across facilities.

ii. Our key rationale behind this is the following:

- PMI patients would also benefit from price transparency for a number of reasons:
    - At any one time the contract is between the patient and the PH provider. Should there be any issues with their PMI provider, e.g. benefit caps, exclusions or excesses, these costs must be paid by the patient
    - As buyers of PMI and/or TPA funds, corporate employers should be able to ensure that their policy holders are getting value for money (e.g. within a specific local area / with a low-cost network)
        - In our experience, there is an increased trend of corporate self-funded schemes managed by Third Party Administrators (TPAs) in the market
    - Transparency of prices paid by PMI providers would ensure that there is visibility in regard to the value that PMI networks drive for the consumer
- All PH providers do not currently price procedures in the same way; they will typically include or exclude various items from total prices and mark up on particular items (e.g. chemotherapy drugs) at a variety of levels
    - This variety of pricing structures used makes straight forward price comparison difficult. Often it is difficult for the patient, or their intermediaries, to understand what is included in quoted prices and assess the total cost of treatment ahead of a procedure

- Nuffield operates using 'fixed cost surgical prices', 'all inclusive' prices for both PMI and self-pay. For self-pay, this also includes consultant fees. Non-surgical procedures are currently non-package due to the complexity and individuality of most medical interventions, though we are keen to investigate models for implementing such pricing

- PMI providers are extremely well placed to provide PH price data across various procedures for comparison

iii. Key considerations going forward:

- The benefits of price transparency across the market (including PMI patient prices) should be investigated by the CC
    - We believe this would not only improve competition between facilities but allow customers to better understand which PMI policies will provide value for money

c. Consultant, Quality

The OFT highlights the shortage of consultant quality information available to patients and their intermediaries. This has important implications on patient choice at the moment of referral. In order to remedy this, the OFT suggests consultants publish outcome and process measures, made available to all relevant stakeholders (GPs, PMIs, PH providers etc.).

i. Nuffield's position

- Across both the NHS and Private Healthcare there is a lack of comparable consultant quality data in order for intermediaries (GPs, etc.) to make informed decisions
    - The necessity for such information is crucial given the greater implications consultant choice has for the customer journey versus the choice of PH facility

- The CC must determine the relevant quality metrics with consultant bodies (Royal Colleges etc.) to ensure that consultants have ownership and trust of this data

ii. Our key rationale behind this is the following:

- The OFT report and all industry research clearly identifies that the choice of consultant is the most important choice made by the patient or their intermediary

- The availability of good consultant quality data is key given the important role the consultant plays in the patient referral pathway (as the OFT has indicated)

- The information needs of relevant stakeholders are likely to be simpler than assumed. Creating quality metrics should therefore not pose insurmountable challenges
    - We believe the key lies in not over complicating the levels of quality/outcome data required. As those often suggested are not widely collected in the NHS and/or reliable measures do not exist, the starting point should be simple, consumer-led indicators.

    - Given the relatively low volumes of consultants' private practices, quality data should be measured across the entirety of a consultants' work (including NHS procedures)

- As with PH facilities, the CC should not underestimate the quantity of consultant quality data available from PMI providers

- PMI providers will use quality indicators in order to provide consultants with recognition on their network or within their maxima

iii. Key considerations going forward:

- Because consultant information is extremely important in ensuring patients' access to care, we believe that the CC should take the opportunity to develop quality metrics that will be of most use to patients and practitioners in the private health market
    - The success stories in the Scottish and Swedish markets of consultant quality information for joint registry being owned by consultants also strongly suggest the CC should develop these in conjunction with consultant bodies

d. Consultant, Price

As well as a shortage of consultant quality information the OFT highlighted a shortage of consultant price information available to patients and their intermediaries. This has important implications for PMI patients in assessing the risk of shortfall from particular consultants. As a remedy, the OFT proposes that consultants provide fee and shortfall estimates up front, as well as transparent first consultation prices.

i. Nuffield's position

- We agree that there is a lack of price information available and broadly agree with the remedies put forward by the OFT, but we also maintain that the role of PMI providers in solving this issue for their policyholders should be investigated further

ii. Our key rationale behind this is the following:

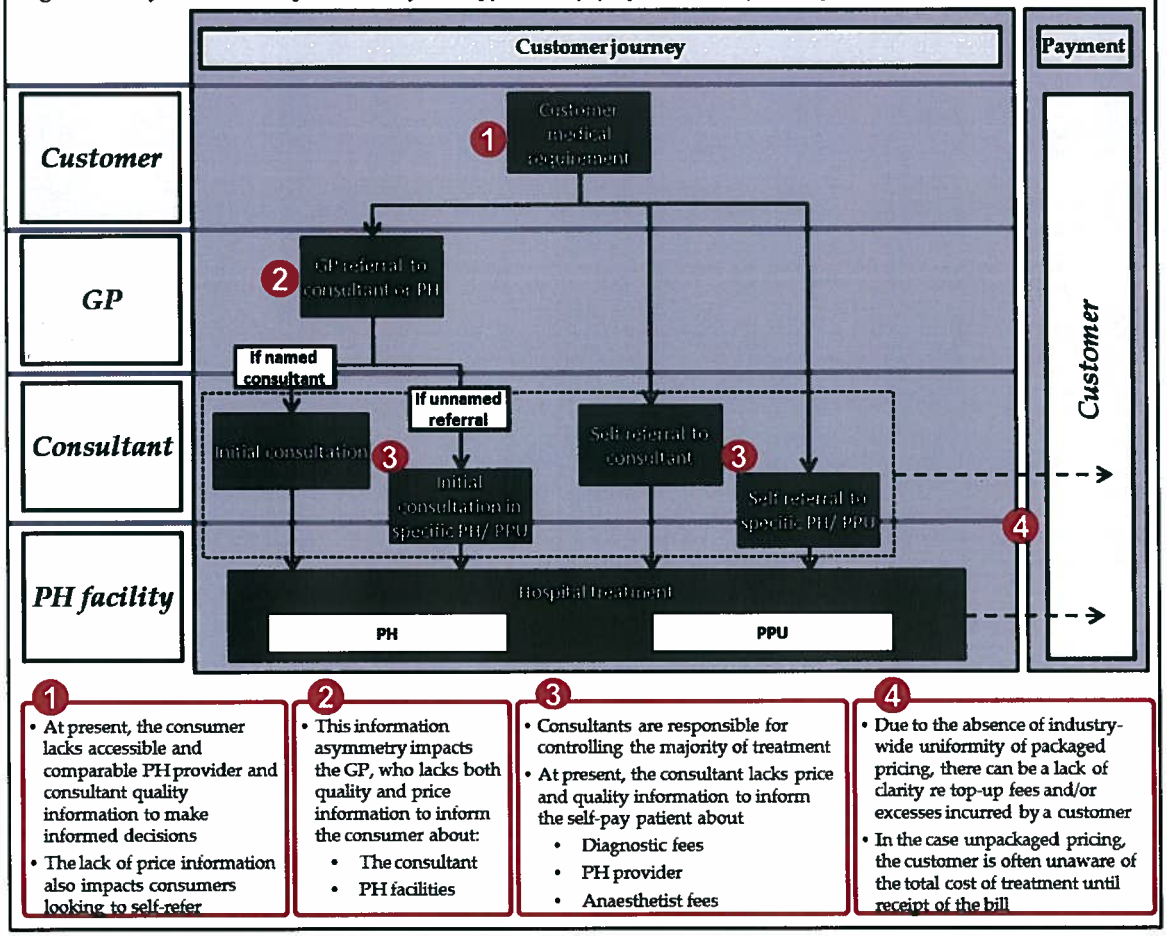
- PMI providers have a role, as brokers, to address consultant price concerns on behalf of their customers (as they do with PH providers)
    - PMI providers are also in a unique position to provide solutions to issues identified around consultant prices, for example by agreeing to pay 'top up fees' for consultants meeting certain criteria/ network inclusion or refusing to recognise consultants who do not meet fee maxima
- Without both consultant quality and price information it will not be possible to fully solve the issue of shortfalls and top up fees
    - As consultant groups with local, regional or national concentration have the possibility to leverage this in order push prices, the issue around shortfalls has the potential to become more acute as groups become more widespread (see 4.)

iii. Key considerations going forward:

- We strongly believe that consultant price information would be beneficial for consumers. We remind the CC, however, that the 'top-up-fee' issue will only be fully resolved if this is combined with the availability of quality data

The impact all four types of information asymmetry have on the healthcare 'customer journey' is summarised in Figure 1.a and Figure 1.b on the following pages.

Figure 1b. Information asymmetries for a typical self-pay customer journey



1
- At present, the consumer lacks accessible and comparable PH provider and consultant quality information to make informed decisions
- The lack of price information also impacts consumers looking to self-refer

2
- This information asymmetry impacts the GP, who lacks both quality and price information to inform the consumer about:
  - The consultant
  - PH facilities

3
- Consultants are responsible for controlling the majority of treatment
- At present, the consultant lacks price and quality information to inform the self-pay patient about
  - Diagnostic fees
  - PH provider
  - Anaesthetist fees

4
- Due to the absence of industry-wide uniformity of packaged pricing, there can be a lack of clarity re top-up fees and/or excesses incurred by a customer
- In the case unpackaged pricing, the customer is often unaware of the total cost of treatment until receipt of the bill

2. Concentration of PH Providers

At a local market level, the OFT identifies examples of extreme concentration, such as areas where there is no alternative fascia PH facility within a 30-minute drive time (a 'solus' facility).

Furthermore, based on PH providers' revenue market shares, the OFT concludes that the market is concentrated at a national market level.

The OFT notes the concerns raised in submissions about the existence of 'must-have' facilities, described as facilities that, due to unique attributes in the local market, are indispensable to PMI purchasers. It does not, however, take a definitive view on identifying such facilities.

Overall, the OFT recognises that areas of high local concentration may convey a degree of market power to PH providers. As a remedy, the OFT suggests putting in place obligations on PH providers in relation to their 'solus' and 'must-have' facilities.

i. Nuffield's position

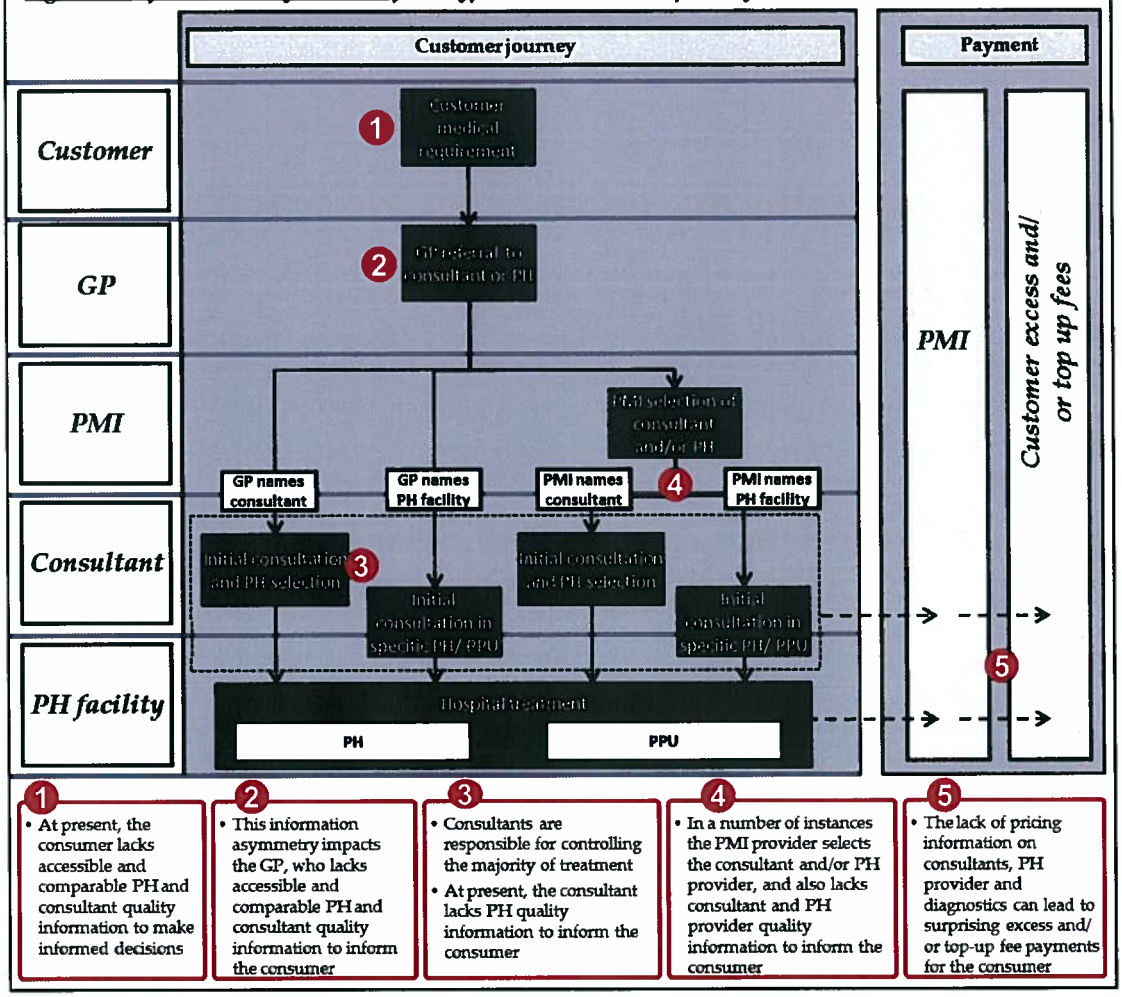
- The OFT has not fully or accurately defined the local and regional markets, or fully understood the combination of factors that create national or regional market concentration
    - This concentration should be considered in the context of the adverse effects of PMI networks which play out to the benefit of larger PH providers with strategic market advantages
- Though the PMI market itself is unlikely to form part of the investigations' scope, the CC should consider the impact of concentration of the PMI market, in particular taking into consideration the volume dependency of PH providers on the two largest PMI providers

ii. Our key rationale behind this is the following:

Local PH concentration

- Local market concentration cannot be simply defined by markets which contain 'solus' facilities, where there is no alternative fascia PH facility within a 30-minute drive time, but additionally must consider:
    - Local market demand, determined by population coverage, PMI penetration and/or corporate market size
    - Local market capacity (i.e. whether demand is close to, or exceeds, the local market capacity provided by a 'solus' hospital or a number of hospitals operating in a local market)
        - This may be at an overall local market level, or for specific specialities or procedures
    - Hospital specific factors (e.g. scale, specialist equipment)
    - Consultant specific factors, such as consultants of a particular speciality limiting the local hospitals in which they practice
    - Degree of inclusion on the large PH provider networks

Figure 1a: Information asymmetries for a typical PMI customer journey



- As such, we use the term 'must-have facility' to define any PH facility that is essential to the provision of PMI treatment in a local market, or to the national coverage required by some PMI policies (i.e. a PMI provider must have access to that facility). 'Must have' facilities may or may not also be 'solus' facilities, as demonstrated by the examples set out below:

		Solus ✓ Must have ✗	Solus ✓ Must have ✓	Solus ✗ Must have ✓	
Description		• Solus hospital exists in low demand market *(e.g. Nuffield Hereford)*	• Solus hospital exists in high demand market *(e.g. Edinburgh)*	• A hospital in a local market that, as a result of long-term exclusive network inclusion and consultant drag effects, is essential for a PMI provider in order to address that local market *(e.g. Bristol, Leicester)*	Where a PH provider has a monopoly position in a regional market, its PH facilities in that market become 'must haves' *(e.g. London HCA)*
Market characteristics determining 'must-have' facilities	**Drive time to nearest PH facility**	>30 minutes	>30 minutes	<30 minutes	<30 minutes
	Local market demand to capacity ratio	Low	High	High	High
	Hospital specific factors	n/a	Low	High	High
	Consultant specific factors	n/a	High	High	High
Impact on local market		• n/a	• Higher pricing • Increased profits for re-investment • Market dominance creating barriers to entry/ competition		

- The negative impact of 'must-have' facilities on the local market is to:
    - **Increase prices:** PH providers can use local power to negotiate higher prices with PMI providers
    - **Increase barriers to entry/ competition:** Must-have facilities create anti-competitive local dynamics such as excess profits for re-investment and 'consultant drag'. Conversely excluded hospitals or new entrants struggle to compete in the market, stifling investment in innovation and service quality improvements, and therefore perpetuating their 'excluded' status
- In the case of London, a market which has a notably high PMI penetration and corporate concentration, a single PH provider has regional dominance and hence all its facilities in that market become 'must haves'.
    - The impact of this is to increase the cost of provision in central London which, due to a lack of transparency on PMI premiums, may result in higher PMI costs for consumers at a national level, in effect the higher costs in the London market are cross subsidised.

National PH concentration

- Although 'must-have' facilities drive some anti-competitive dynamics in the local market, it is at the national level that they combine with other market features to materially impact market competition
- National PH concentration cannot simply be defined by market share of revenues. As well as the scale of PH providers, the proportion of 'must-have' facilities in a PH provider's portfolio also needs to be considered. As PMI providers currently procure PH services at a national

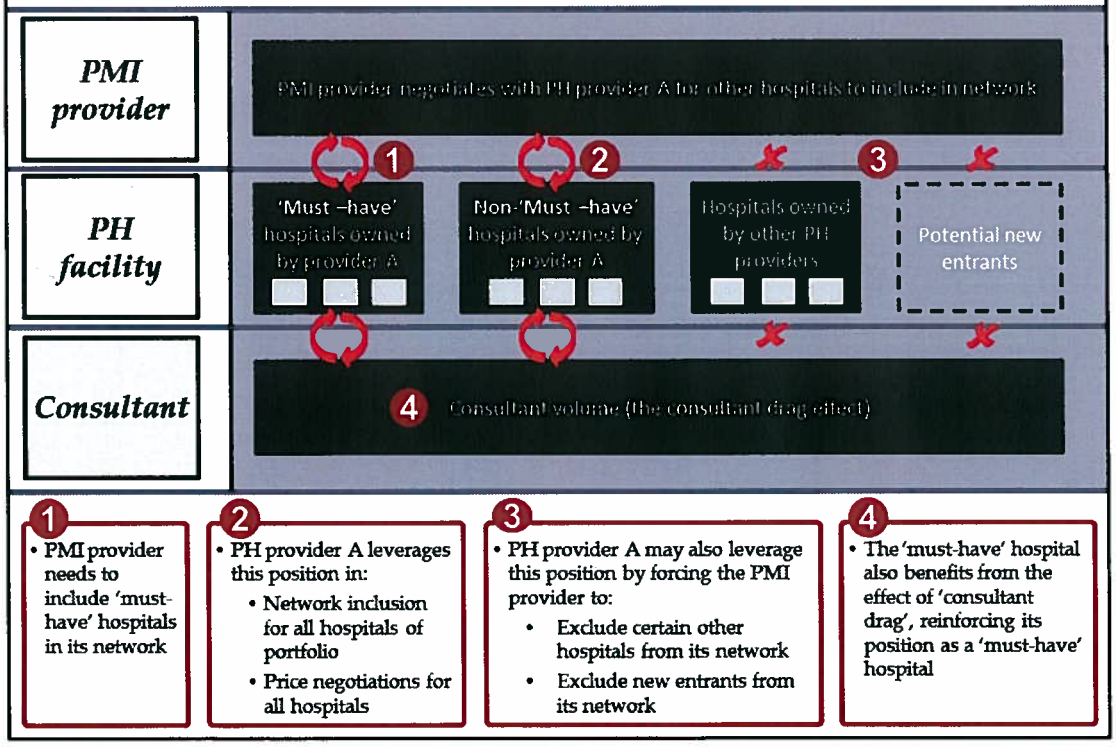
network level, PH providers with a critical mass of 'must-have' facilities can leverage a combination of 'must-have' facilities and scale to negotiate in two areas:

- **Network inclusion:** Large PH providers leverage 'must-have' hospitals to include their entire hospital portfolio on networks. As a direct or indirect consequence, this can lead to the exclusion of smaller PH provider facilities from a PMI network
- **Higher pricing:** Large PH providers leverage 'must-have' hospitals to not only command pricing in those hospitals, but across their entire portfolio

- Furthermore, as a result of PMI market concentration, the buyer power of the larger PMI providers gives them the ability to exert excessive price pressure on other PH providers who do not possess a critical mass of 'must-haves' to exert any bargaining power

- These effects are shown in Figure 2 below

Figure 2. Illustrative impact of must-have hospitals on national market



- Market concentration not only creates ineffective competition but also adversely impacts the consumer in a number of ways:
  - **Increased cost of care:** The higher PMI prices negotiated by the largest PH providers are ultimately passed on to the customer
    - The lack of pricing and quality information (see Section 1) serves to hide this issue at present

- **Reduced patient choice:** Facilities operated by smaller PH providers are often excluded from PMI networks as a result of large provider national network contracts

- **Access to less innovative, lower quality facilities:** The largest PH providers continue to benefit from network inclusion, higher pricing and consultant drag

    - Consequently, where smaller providers are excluded from networks they struggle to compete in the market, which in turn stifles investment in innovation and improving service quality

iii. Key considerations going forward:

- Though the OFT identified certain factors affecting concentration, such as the existence of 'solus' and 'must have' facilities, it did not fully set out to understand or evidence how these may affect PH market power. The CC should therefore undertake a more thorough investigation of the factors that define PH market concentration

- In order to understand the level of market power certain providers may enjoy, the CC should investigate in detail the number of strategic 'solus' & 'must have' facilities by PH provider, and the impact that these have on network negotiations and wider market competition

    - This will require the CC to arrive at an agreed upon definition of 'must have' and strategic 'solus' facilities, something the OFT failed to do. We look forward in helping the CC defining these in more detail, and also believe input from PMI providers in particular would be helpful in this area

    - More specifically, we believe the CC's investigation should encompass the analysis of certain concentrated local and/or regional markets (e.g. London, Edinburgh)

- Further to the above, Nuffield also looks forward to evidencing the impact of PH concentration on network inclusion and exclusion (see Section 4.a of this letter)

2.i PPUs and Competitive Neutrality

The OFT did not consider that the NHS as a whole formed part of the relevant product market. The OFT's view was that PPUs did form part of the relevant product market, though their competitive constraint on other PH providers varied on a case by case basis.

In the OFT's view, partnership agreements between PPUs and PH providers therefore have the potential to exacerbate or alleviate concentration in local markets. It therefore recommended to the Department of Health (DoH) that PPU partnerships not be undertaken with a provider that has more than a certain share of the local market.

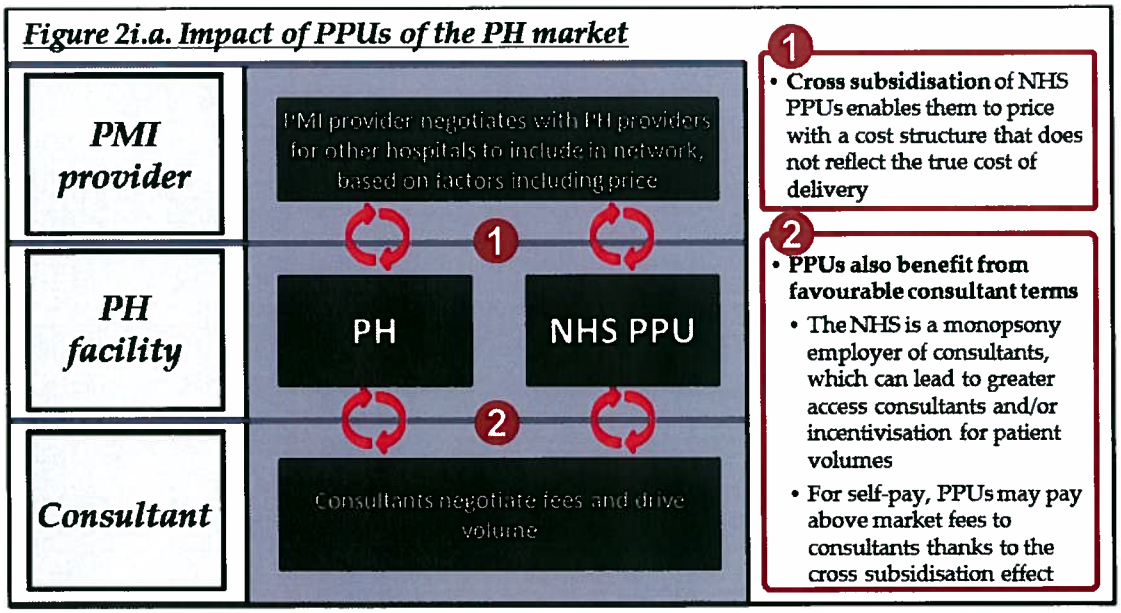
i. Nuffield's position

- In our opinion, PPUs currently constitute a competitive constraint on PH providers. We expect this to be further exacerbated going forward as current NHS reforms raise the Foundation Trust (FT) private work cap to 49%
    - As such, the need for competitive neutrality of NHS PPUs is crucial. Indeed, the risks of PPUs having an unfair competitive advantage due to cross-subsidisation, the NHS monopsony position as a consultant employer, or market monopoly for provision in certain areas (e.g. A&E), are high

ii. Our key rationale behind this is the following:

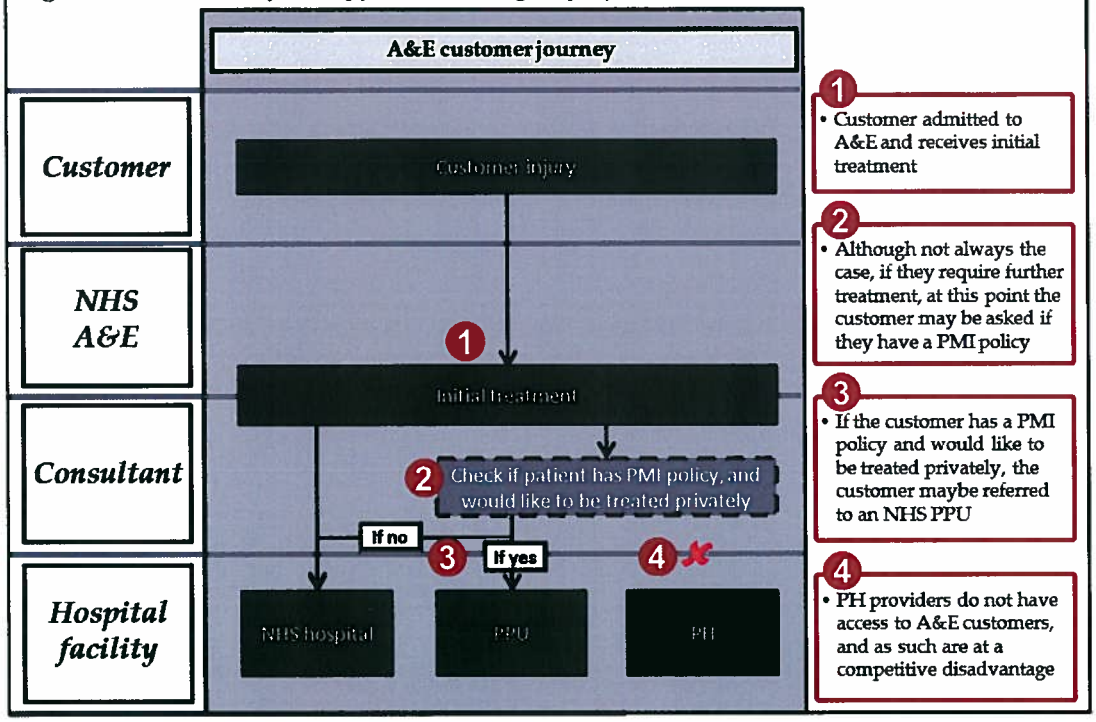
- We believe PPUs benefit from a unfair competitive advantage due to cross-subsidisation from the NHS and the NHS monopsony as a consultant employer (see Figure 2i.a)
    - The cross-subsidisation of the cost of capital, pensions (NHS off balance sheet pension liabilities), staff (e.g. junior medical staff)
    - The abuse of the NHS monopsony position as consultant employer, through incentive arrangements for private practice or lock-in arrangements for NHS work

Figure 2i.a. Impact of PPUs of the PH market



- Furthermore, NHS PPUs are, to a certain extent, vertically integrated with NHS GP services and horizontally integrated with NHS secondary care services. As such, there is a significant risk around preferential internal referrals to NHS PPUs (e.g. A&E - see figure 2i.b)
    - Though not widespread today, to a certain extent NHS 'Top Up' arrangements already encourage this type of unfair competitive practice

Figure 2i.b. Customer journey for PMI emergency referral



- The above issues are likely to be exacerbated by the removal of the private work cap proposed in current NHS reforms

iii. <u>Key considerations going forward:</u>

- Although Nuffield does not argue that the NHS as a whole should form part of the product market of this investigation, we do feel that PPUs are part of the relevant product market and that, particularly in light of current reforms, the role the NHS may have in granting PPUs an unfair competitive advantage should be fully investigated.

3. Concentration of Consultants

As part of its report, the OFT identified that in a number of local markets there is a high concentration of anaesthetists organised in Anaesthetist Groups (AGs). As patients have limited fee visibility and choice in anaesthetist, the OFT believes that this concentration reduces price competition in local markets.

Though the OFT acknowledges that concerns about all consultant groups were raised during the consultation phase of its investigation, it has left it to the CC's discretion to look into the situation in regard to all consultant groups.

i. Nuffield's position

- We agree that there is a concentration of anaesthetists organised in AGs in local markets. However in our view, this is also the case for all consultant specialities, where we observe an increasing trend towards grouping together (vs. remaining 'sole traders')

- By organising in groups, consultants can enjoy a market power that they can leverage in similar ways to the largest PH providers. This takes the form of upward pressure on fees agreed with PMI providers and any incentives agreed with PH providers (e.g. 'all or nothing' exclusivity agreements conditional on obtaining a share of PH provider revenues)

- We believe that typically these groupings are unincorporated associations, with the consultants remaining under their existing sole trader (LLP) status, can lead to potential unintended consequences

    - The practice of consultant groups setting or negotiating prices may therefore constitute price collusion and be anti-competitive

ii. Our key rationale behind this is the following:

- As was discussed in the OFT market report, in the majority of referrals, the consultant is of key importance in the referral pathway as the intermediary that selects the PH facility where the patient will be treated

    - For PH providers, this means that attracting consultants is essential in accessing patient volumes

    - From a PMI provider's perspective, the availability of good quality consultants is a key criterion in assessing the network inclusion of a new PH facility

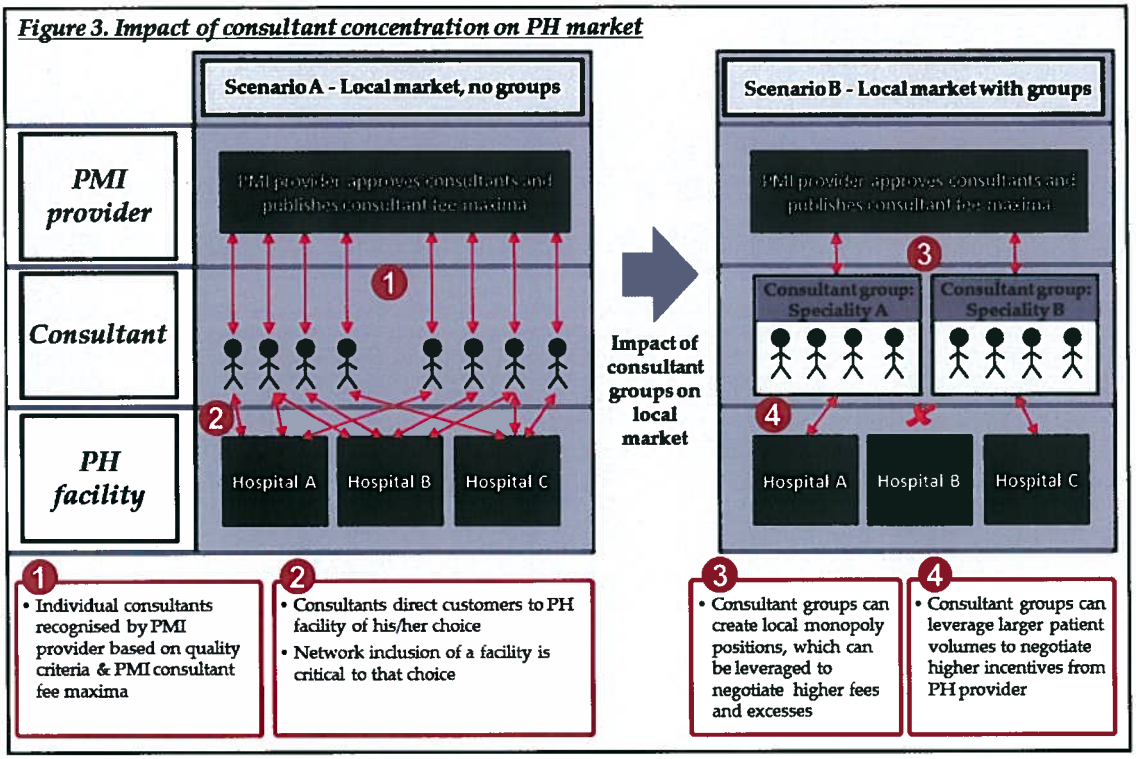
- Consultant group practices around PMI fees and PH provider incentives are likely to raise the cost of healthcare without associated benefit to the consumer. Indeed, these groups are often used purely to leverage additional revenues (See Figure 3 below)

    - These practices increase fees paid by PMI providers without any improvement or change to the care pathway for the consumer

    - They also stifle innovation by reducing PH providers' ability to invest in service improvements or by forcing PH providers to raise prices

- Furthermore, consultant groups also have the adverse effect of reducing consumer choice

Figure 3. Impact of consultant concentration on PH market



- Nuffield believes the practices of certain consultant groups around pricing requires further investigation
    - As consultants are self-employed practitioners, we are concerned that the practice of consultant groups in setting or negotiating prices with insurers constitutes price collusion and is therefore most likely anti-competitive
        - This is, to a certain extent, supported by the OFT's ruling in 2000 that it was anti-competitive for the British Medical Association to publish fee schedules for consultants

iii. Key considerations going forward:

- We believe that, for the reasons above, the CC should not only investigate the concentration of anaesthetists in AGs but also fully investigate across all specialities the impact consultant groups have on competition and patient choice
- Nuffield is prepared to evidence the increasing number of instances in which we been faced with consultant groups seeking to leverage their position to increase revenues or privileges

3.i Concentration of GPs

Although the OFT briefly mentions the subject of GP incentives, it does not in any way investigate the impact of GP groups on the market.

i. Nuffield's position

- The investigation of GP groups is important, particularly in the light of the NHS reform bill, which will hand over commissioning and budget responsibilities to GP groups

ii. Our key rationale behind this is the following:

- The GP occupies a key position along the patient pathway
    - As was evidenced by the OFT, they are trusted and heavily relied upon by patients to direct them towards the best consultant and/or treatment available
- There are risks that, as with consultant groups, there are unintended anti-competitive consequences of concentration in GP groups
    - In particular, there are risks around preferential referrals to NHS and NHS PPUs
        - This is likely to occur in instances where triage services are provided by secondary care providers such as NHS trusts, to which GPs can be instructed to refer directly (e.g. Ipswich)
    - There are also risks around preferential referrals to PH providers, either as a result of incentivisation or vertical integration
        - GPs are able, for example, to leverage their NHS status to direct patients to their own private services; we believe this may occur at Care UK facilities in York
        - Where vertical integration of a PH provider occurs, as is the case in Nottingham, where Circle provides triage services, we believe there is a significant risk that patient choice be restricted or even removed
- There is a need to 'future proof' the industry ahead of NHS reform
    - The current NHS reforms are designed to encourage GP concentration into Clinical Commissioning groups. Whilst this has distinct advantages for the NHS system we believe it has real dangers for the competitiveness of the PH market
        - In areas with restricted NHS services, GPs are likely to preferentially direct patients to the NHS and/or NHS PPUs
        - Given the dependence PH providers now have on NHS volumes, any restriction in NHS commissioning will have a direct impact on the private market
    - With the commissioning powers they are set to receive, GP groups are likely to become more privy to incentivisation offers

iii. Key considerations going forward:

- We believe the role of the primary care market in influencing competition in the PH sector has been overlooked by the OFT. Going forward, we believe the CC should focus on investigating whether GP group concentration or the vertical integration of PH providers is likely to negatively impact the market's competitiveness

4. Barriers to Entry and Expansion

a. PMI network recognition

The OFT acknowledged that network recognition and associated 'consultant drag' create significant barriers to market entry for new entrants. The combination of 'one in, all in' negotiation tactics, alleged pricing threats and contractual provisions create an environment where network recognition of new facilities is often not economically viable.

In order to remedy this, the OFT proposes to ban PH providers from using price threats (where PMI inclusion of a new facility results in a network wide price increase) or any other means in order to deter PMI providers from recognising new rival facilities on their network.

i. Nuffield's position

- Nuffield does not believe that networks in themselves are a barrier to competition, but that it is the exclusive nature and lack of regular retendering of some PMI networks combined with the market power of the largest PH providers and the resulting 'consultant drag' effects that serve to adversely impact the market (see Section 2)
    - Nuffield supports the OFT view that it is the combination of PMI networks, PH provider market power and 'consultant drag' that constitutes the crux of the competition issue in the Private Healthcare market
- The influence of PH providers with market power (i.e. those with a 'critical mass' of must have facilities) on PMI networks may result in the exclusion of other facilities that are of comparable quality but lower cost
    - This creates a pernicious cycle, whereby the excluded facilities are unable to gain the market share needed to generate cash to re-invest in maintaining adequate levels of quality and innovation in order to compete
        - In 2008, Nuffield was forced to dispose of hospitals that had suffered network exclusion for a number of years because they were 'trapped' in this declining cycle. Some of these hospitals immediately obtained network inclusion when bought by a large PH provider
    - Our view is therefore that these adverse dynamics have led to long term and significant revenue damage and/or loss to providers disadvantaged by network exclusion
        - The CC should therefore consider recourse to remedies that will redress the historical impact of this issue
- The net effect of the adverse network effects described above on consumers is therefore not only to reduce patient choice but, in the long term, reduce access to high quality, cost effective healthcare

ii. Our key rationale behind this is the following:

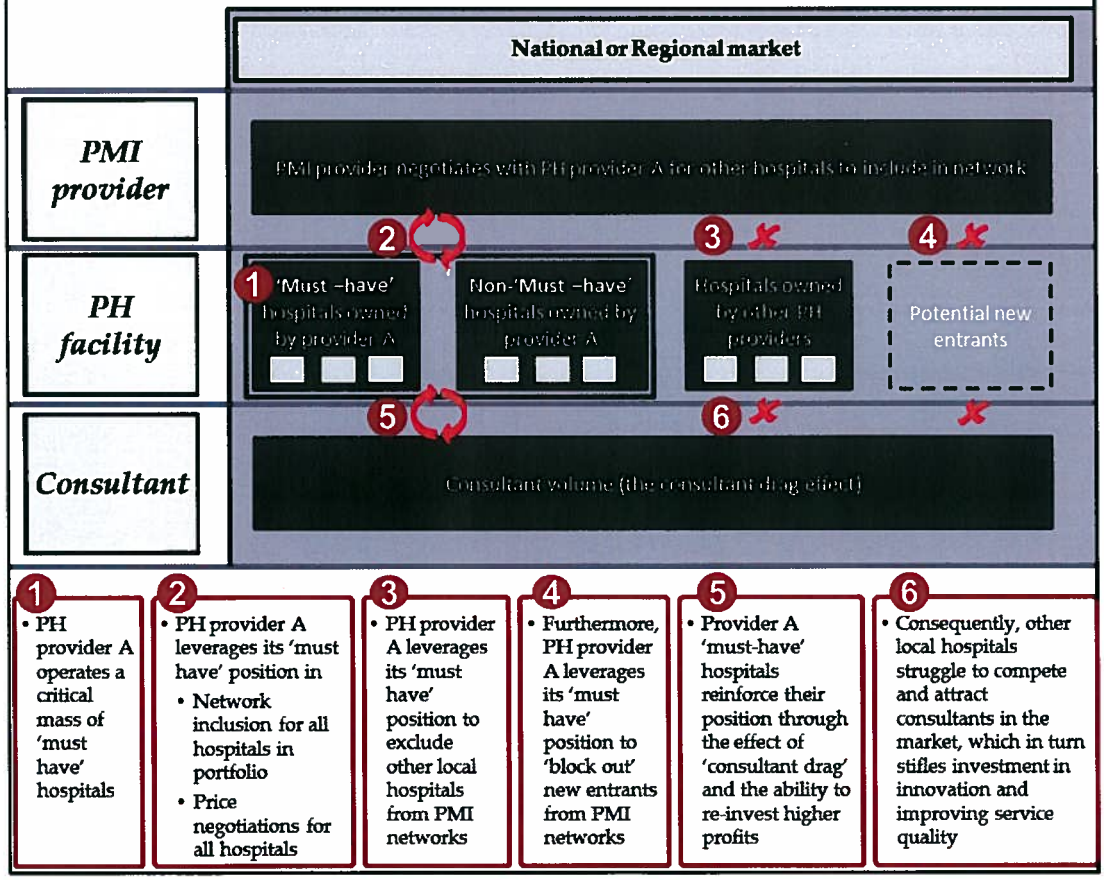
- Networks were originally set up by PMI providers in order to select PH providers based on
    - Quality of facilities and consultants

- Coverage
- National pricing

- However, as described in Section 2, large PH providers are now able to leverage their scale and critical mass of 'must have' facilities in order to
  - Negotiate higher prices across their portfolio
  - Gain network inclusion of all the facilities in their portfolio, sometimes on an exclusive basis

- As a direct or indirect consequence other PH providers without the ability to leverage any market power are excluded from PMI networks in certain areas (regardless of price/quality merits) or subject to excessive price pressure from the largest PMI providers

Figure 4a. Illustrative impact of must-have hospitals on networks



- This not only creates ineffective competition in the market but also, as described in Section 2, impacts the consumer in a number of ways:
  - **Increased cost of care:** The higher PMI prices negotiated by the largest PH providers are ultimately passed on to the customer

        - The lack of pricing and quality information (see Section 1) serves to hide this issue at present

    - **Reduced patient choice:** Facilities operated by smaller PH providers are often excluded from PMI networks as a result of large provider national network contracts

    - **Access to less innovative, lower quality facilities:** The largest PH providers continue to benefit from network inclusion, higher pricing and consultant drag

        - Consequently, where smaller providers are excluded from networks they struggle to compete in the market, which in turn stifles investment in innovation and improving service quality

iii. <u>Key considerations going forward:</u>

- The CC should investigate the impacts of PH concentration and network inclusion in a lot more depth than was attempted by the OFT

    - In addition to the analysis suggested in Section 2, we believe the CC should aim to undertake detailed pricing analysis across the different PH providers at a local and national level. This would enable the commission to determine whether, in real terms, there is any price gain from networks that may go to justify their current use

- Nuffield is also prepared to provide information and analysis around the hospitals it was forced to dispose of as a result of network exclusion, which immediately obtained network inclusion when bought by BMI/Spire

    - This should serve both as evidence of the impact of network exclusion, and the influence of scale/ market power on network inclusion

b. Consultant incentives

The OFT concluded that incentives paid directly or indirectly by PH facilities to consultants encourage them to treat all, or a higher number, of their patients at that facility. As such, this may discourage consultants from treating patients at the facilities of new entrants attempting to offer competing PH services.

As a remedy, the OFT suggests banning PH providers with market power from operating consultant incentives schemes as well as imposing transparency requirements for consultants, e.g. providing details of any incentives to patients and GPs.

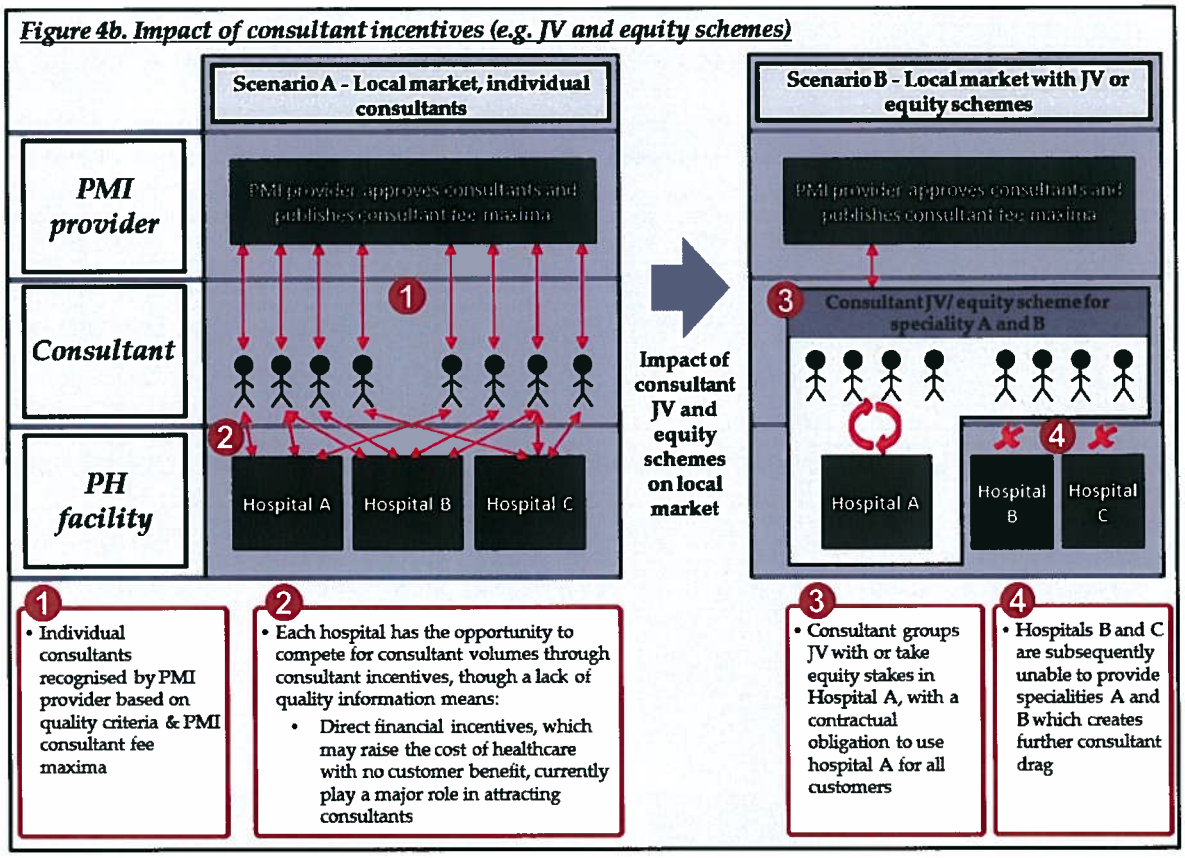
i. Nuffield's position

- We believe the CC should go further than the OFT in the remedies it proposes to address this issue: all direct financial incentives to consultants should be banned
    - In our opinion all PH providers, regardless of market power, create barriers to entry by providing financial incentives to consultants (direct and indirect)
    - They prevent effective competition between existing PH providers, 'artificially' raising the cost of care and restricting patient choice
- In the case of non-financial incentives (such as enhanced facilities) provided to attract consultants, we would argue that these encourage competition between providers as well as innovation, and are therefore beneficial to the market

ii. Our key rationale behind this is the following:

- As was discussed in the OFT market report, in a majority of referrals the consultant occupies a key position in the patient pathway as the intermediary that selects the PH facility where the patient will be treated
    - For PH providers, this means that attracting consultants is essential in accessing patient volumes.
    - From a PMI provider's perspective, the availability of good quality consultants is a key criterion in assessing the network inclusion of a new PH facility
- All financial incentives create barriers to entry regardless of a PH provider's market power by exacerbating the 'consultant drag' effect
    - These incentives and the contract provisions these may entail (e.g. commitments to practice at a single facility) act as a consultant 'lock in', preventing other PH providers from using facility quality as a means of attracting consultants to a new prospective facility
- Consultant financial incentives prevent effective competition in the market by forcing PH providers, in the absence of readily available facility quality information, to compete on financial incentives alone to attract consultants. This practice ultimately restricts patient choice and raises the cost of care without utility gain for patients
    - Direct financial incentives restrict patient choice and raise PH provider costs without any associated quality improvements for the consumer. In the long term, this cost stifles innovation by reducing PH providers' ability to invest in service improvements or by forcing them to raise prices

- Indirect financial incentives in the form of JVs or other equity style arrangements reduce patient choice by capturing consultant referrals: consultants are not employees but sole traders and therefore incentivised to direct referrals and restrict competition



- Non-financial incentives, such as improving equipment or operating theatres in order to attract consultants, have a positive impact on the market by stimulating competition and ultimately resulting in innovation and better quality care for patients

iii. Key considerations going forward:

- In our opinion, consultant financial incentives are a key issue that needs to be addressed as part of the CC's investigation. They not only act as barriers to entry but also as a wider constraint on efficient competition between existing providers

    - We therefore believe the CC should go further than the OFT in the remedies it proposes to address this issue

c. GP incentives

Though it does not investigate the issue of GP incentives in any depth, the OFT's report does highlight existing evidence of PH providers using referral incentives for GPs. Building on the evidence around consultant incentives, the OFT acknowledges that the emerging trend GP incentives has the potential to develop as a barrier to entry.

i. Nuffield's position

- All financial incentives to GPs should be banned, and any non-financial incentives that may exist should be made fully transparent to patients
    - This should include also equity schemes under which GPs are awarded shares in PH facilities

ii. Our key rationale behind this is the following:

- The GP plays a key role in the referral process: as the trusted first port of call for the patient, the GP ultimately has the power to skew the entire patient journey
    - We believe it is contrary to a GP's professional integrity to influence their clinical decisions around patient treatment in exchange for financial incentives
- Additionally, GP incentives are likely to further exacerbate the GP concentration issues highlighted earlier in this letter

iii. Key considerations going forward:

- The CC should investigate the impact of GP incentives beyond the extent to which the OFT has. Though their use may not be widespread today, the CC should pre-empt this issue by enforcing remedies in order to prevent any adverse effects on competition emerging in the future.