

AXA PPP healthcare Limited (“AXA PPP”) feedback to the Competition Commission (“CC”) on the provisional findings and notice of possible remedies

AXA PPP welcomes the publication of the CC’s notice of provisional findings and notice of possible remedies in relation to its investigation of the UK private healthcare market. This submission summarises our response to both documents.

1 Provisional findings

1.1 We broadly agree with the provisional findings, which are largely consistent with our experience of how the market operates in practice, and are encouraged by the direction that the investigation is taking.

1.2 We would highlight two areas of exception as follows.

Consultant groups

1.3 We are surprised and disappointed by the CC’s provisional finding, that the formation of consultants groups, and in particular anaesthetist groups, does not have an adverse effect on competition (“AEC”). It would seem to us, in principle, that price agreements/arrangements between significant concentrations of anaesthetists in an area are likely to have an adverse effect on competition. Whatever the legal structuring adopted by these consultants, the result will be substantially reduced price competition.

1.4 While we recognise that the structure of anaesthetic groups (“AGs”) can vary, as to whether it is a loose association, LLP with shared profit etc., we consider it important that the CC does not allow any perceived benefits of such structures to detract from the impact on local competition that such AGs can have. We contend that neither collective price setting nor a group structure is necessary to realise benefits such as out of hours cover, shared expertise etc as identified by the Association of Anaesthetists in Great Britain and Ireland (“AAGBI”), which is the outcome of doctors working together rather than the result of a group structure with collective pricing and shared revenue or profit.

1.5 We consider that the CC may have missed an important point of principle in considering whether there is an AEC in this area. Anaesthetists operate in highly localised areas and in some cases the group can create what is a self-evident monopoly. As an example we would cite the \times group (“ \times ”) which covers a wide area centred on \times . Our analysis shows that of the 57 anaesthetists who work in either (or both) of \times hospitals, 12 do not appear to carry out private practice according to AXA PPP’s records, and of the remaining 45 who do practice privately, (98%) are members of the \times . The \times covers a wide area and sets prices collectively; this effectively means that private customers have no choice but to deal with members of the group at the published prices they have agreed. This would appear to be a clear feature of the market in \times which is adverse to competition.

- 1.6 The CC has pointed out that there have been peaks in the past of the formation of consultant groups¹ which no doubt have been at times when the benefits to consultants of having such groups has been made to appear more acceptable such as the decision by the OFT in April 2003² which said:

“The OFT’s investigation was initiated by a complaint made in May 2001. The complainant alleges that anaesthetists in a number of local areas had formed themselves into groups and agreed within those groups the prices that each anaesthetist will charge for their private professional services. During the investigation a complaint from an individual was received in respect of NAG. Following an initial examination of the complaints there were reasonable grounds for suspecting that the aforementioned groups had agreed within their groups the prices that each anaesthetist would charge for their private professional services.”

“The OFT considers that each of the aforementioned groups (see link below for list), save for GAS (Guildford Anaesthetic Services), operates as a single undertaking for the purposes of competition law and therefore an agreement between the members of each group (within their respective groups) as to the levels of fees to be charged for their private professional services, will not amount to an agreement between undertakings.”

- 1.7 In addition we would note that the current AAGBI guidelines on Independent Practice 2008 on the AAGBI website³ say:

- *Page 4 - The main purpose of private practice is the income that it generates.*
- *Page 11 - Setting fees: Each consultant should determine his or her own fees. Agreeing with a group of local consultants to charge the same fee as other group members can be considered anti-competitive and should be avoided unless the group is trading as a partnership with an established legal identity. If there is doubt about the trading status of a group of anaesthetists, expert legal advice should be sought.*
- *Page 26 – Mentions that a group can maximise its strength in negotiating with PMIs, which clearly indicates that it can allow the anaesthetists to charge more than independents negotiating individually.*

- 1.8 We have previously submitted that AAGBI guidance contains a number of prescriptive clauses on pricing.⁴ In our experience the fee stated on the GAS website does not always reflect what the patient is charged, as additional services that we consider to be part of the service, such as pre-operative assessment, are added to the fees. We believe that the AAGBI’s own Voluntary Code of Practice is therefore frequently disregarded.

¹ Source : Appendix 7.1 to the Provisional Findings report

² See: <http://www.of.gov.uk/OFTwork/competition-act-and-cartels/ca98/decisions/anaesthetists-groups>

³ See: <http://www.aagbi.org/publications/publications-guidelines/G/L>

⁴ See: question 49 of the Market Questionnaire, the 2008 AAGBI Voluntary Code of Practice for Private Practice states in section 4 - During Treatment, in paragraph 4.2 that a consultant “should not break up the elements of a single surgical or anaesthetic procedure into its constituent parts in order to maximise the benefit provided to the patient by his PMI.” This is also reiterated later, in Section 5 - After Treatment, in paragraph 5.4 “The consultant may include a descriptive narrative of the procedures performed in the account in order to assist correct coding by the PMI but should not do so in order to maximise benefit payment” and in 5.8 “The consultant should not normally allocate portions of his fee to particular codes or narratives. The fee should represent the whole amount payable for the entire treatment episode.”

- 1.9 Further, in the same way that the CC's survey found that 3% of consultants admitted to having incentives was subsequently found to be significantly under reported, it is possible that the 45 groups which provided full responses to the CC's survey were not representative of AGs as a whole in relation to those which set prices at the group level. AXA PPP is concerned not only with the low response rate but also by the real possibility that the non-responses were not random. If possible we hope that the CC may seek to gather further evidence.
- 1.10 We have submitted previously that we are particularly concerned with anaesthetists since they represent the largest number of consultants by specialty, but also operate in a way in which the patient often does not have choice in practice, as the anaesthetist is most often selected by the consultant. We are disappointed that CC has not acted on its earlier thoughts regarding transparency of anaesthetists' costs to the consumer and has not required that anaesthetic services should be billed by the treating hospital or lead specialist. Consumers have considerably less choice in such support services.
- 1.11 Given the CC's provisional finding we now have a significant concern that there is a strong likelihood that consultants in general, and anaesthetists in particular, will interpret the CC's current findings as a carte blanche to exploit the potential of consultant groups in respect of collective pricing, to the detriment of the consumer.
- 1.12 In light of the above, we recommend that the CC reconsiders its position as regards consultant groups. We believe this would serve as a clear basis for future possible review in this area and/or form the basis for deterrent action to the benefit of the consumer. We have a number of thoughts and legal arguments which we wish to make and we propose to revert separately on these points.

Market power of hospital groups

- 1.13 We have commented previously⁵ on our concerns about the CC's approach to the analysis of hospitals that are deemed to have market power. AXA PPP welcomes the conclusion that there are hospital groups which possess substantial market power in particular localities, which accords with AXA PPP's views. We believe there are several significant differences between the hospital-by-hospital local analysis of the CC and the Hospital Group/Insurer question. In particular the criteria which identify market power for an individual hospital operating in a locality can be different from those in the Hospital Group/Insurer national bargaining context. For example, the latter will also need to encompass the critical difference between self-pay markets and PMI where, in contrast to self-pay, PMI is contracted for ex ante when the individual does not know whether he or she will fall ill, if so with what condition (and hence which hospital is required) and, having purchased or been supplied with insurance, does not pay (at the point of treatment), and hence has little incentive to "shop around". With corporate provision these issues go a level deeper and a company will typically wish to see provision of hospitals in its PMI provider's network that match the needs and expectations of substantially all of its staff, and in particular senior decision-makers, and which matches the geographic spread of their employees.

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- 1.14 Accordingly, from the perspective of a PMI provider, the issue is more one of whether a hospital has to be included in the network to satisfy important customer groups, rather than local substitution patterns of marginal individual customers. One consequence of this distinction is that that the principal private hospital in a city that is in the commuter belt of any major centre of employment would typically have to be included in the network even if there are a number of private hospitals in a radius around the city that might constrain it in the self-pay market.
- 1.15 Our focus has therefore been to consider the potential outcome of the analysis rather than the methodology. AXA PPP considers that in assessing the market power of a hospital chain, it is important to examine which hospital groups are must-deal partners for provision of a particular category of health insurance such as Large Corporate or Individual segments. This is closely connected to the question of whether it is possible to assemble "complete" coverage of the requisite quality and location, given the individual or corporate customer, without contracting with a particular hospital group. We will revert separately on this topic once we have had opportunity to consider the list of circa 20 hospitals identified by the CC for potential divestment.

Possible remedies

Central London divestiture

- 1.16 We agree that divestment is the only remedy which will resolve the current lack of competition in central London. Our observations outlined further below, it should be noted, have been formulated prior to us being privy to the proposed list of circa 20 hospitals developed by the CC. We have considered the minimum number of hospital groups, together with key specialties, that we believe would create effective competition.

Divestment outside of London

- 1.17 Outside of London, although we agree that BMI and Spire may have a greater degree of market power in some geographical regions, we do not currently experience the same level of disadvantage that we do with HCA in London. We are sceptical in the round of a remedy that requires BMI and Spire to divest hospitals. However we are open minded to the CC's approach and will review the potential hospital divestitures identified by the CC to consider the potential implications.

Tying and bundling

- 1.18 In terms of preventing tying and bundling (Remedy 2a) we see this as a particularly complex area. AXA PPP has been resistant, usually successfully, of 'one in, all in' clauses, and also clauses that prevent us as an insurer, removing and adding hospitals to our network. From an insurer's perspective seeking to negotiate effectively, AXA PPP needs to be able to negotiate prices and to reserve the right to be flexible in terms of which hospitals we recognise in our network (and which we do not) and therefore AXA PPP supports a remedy that supports our ability to review our network periodically and add or remove provision. Essentially, the threat of a hospital not being accepted in the network is the only method in which a PMI provider can exert price leverage against a

hospital chain. As in any market, price competition requires the possibility that a firm loses business if its price is not competitive. Accordingly, anything that undermines the right not to purchase the services of a particular hospital, or weakens the credibility of that threat, automatically weakens the effectiveness of price competition. However AXA PPP regards this remedy as of secondary significance compared to breaking the market power and leverage of hospital chains in the first place.



- 1.19 However, as the CC has identified, there are difficult issues when, after a contract has been negotiated, a competitor builds a new hospital. In particular, the “flipside” of a quantity discount is that loss of volume triggers a price increase, and an entrant hospital has to compete with the marginal price of the volume contract. One issue is that incumbent hospital groups often seek to use the proposed admission of a new rival hospital to the network to re-open previously settled pricing agreements, often demanding a price rise to “compensate” its losses due to increased competition. AXA PPP believes that the instances of a new hospital are few, and even in such case, is not material in the context of the total hospital group. For example, where a hospital chain provides 50 hospitals to a PMI provider, a single entry new hospital entry affects only 2% of its portfolio. A remedy which supports new entry could therefore be that clauses permitting hospital groups to reopen pricing contracts, in response to a relatively small level of tendering around new entry, are prohibited.

Local pricing

- 1.20 In terms of hospital group pricing (Remedy 2b) we believe that the PMI/Hospital Group negotiating balance will be significantly improved through executing the divestments. As noted above we see little need to change many aspects of the hospital group/ PMI contracting arrangements. We believe that PMIs should continue to negotiate on a periodic basis and should be permitted to create limited networks to encourage competition. From an insurer’s perspective we want to be able to negotiate prices and to reserve the right to be flexible in terms of which hospitals we recognise in our network and those which we do not. In the event that there is a new entrant we believe the optimal solution is to require a tender process for the local area, and that the effect of such tender should not reopen the rest of the agreement.
- 1.21 AXA PPP does not support this remedy and believes that it has potential for negative consequences. As for Remedy 2a AXA PPP regards this remedy area as of secondary significance compared to undermining the monopolies which allow hospital chains to exert market power and leverage in the first place.

PPU bidding

- 1.22 AXA PPP supports the CC’s proposed remedy in respect of preventing the owner of a hospital in a Single or Duopoly area from partnering with a local NHS trust to operate Private Patient Units (“PPU”). AXA PPP believes that if set up and run appropriately PPUs are able to offer some competition to stand-alone private hospitals. As identified by the CC, developing new or under-performing PPUs could be a cost-effective way of new provision entering a market and providing contestability in Single and Duopoly areas. This competition will not be achieved if the existing owner of the Single or Duopoly hospital becomes the manager of the

new PPU. Whilst a supplier may have an interest in taking over, developing and managing a PPU close to one of their private hospitals to expand in the location, the objective for their interest is likely to be equally motivated by the desire to block competition against their facility.

Incentive schemes

- 1.23 We are pleased that the CC has recognised that incentive schemes influence behaviour and have been widely adopted within private healthcare. We agree with the CC that these schemes give rise to an AEC. We agree with the proposals in Remedy 4 that hospital operators should be prevented from offering to consultants any incentives in cash or kind, direct or indirect. We consider that similarly consultants should be prevented from asking for, or accepting any such incentives. It is our view that the suggestion in Remedy 4 that incentives be allowed where they may reduce a barrier to entry should be removed and that all incentives of any kind, including equity ownership, should be banned. We recognise that some level of carve out may be required where ownership is outside the recipients' control, such as collective investments, however we would expect this to be a tight exemption.
- 1.24 In addition we would point out that there is further action which can and should be taken. Whilst a ban on incentives would be a significant step in the right direction we remain concerned that any ban may be partial or imperfect, and capable of circumvention by an inventive hospital operator. The motivation provided by excessive profit margins in specific areas ie. those such as tests and scans that are easily influenced by incentives, will still exist and these excessive profits, in and of themselves, represent a significant consumer detriment. This is discussed further below in our proposal for a new remedy.

Information availability

- 1.25 We agree with the CC findings that there is a need for more and better information to strengthen the market and support informed choice by consumers. We agree that the market would work better if consumers exercised more choice in the selection of specialists and hospitals using a combination of price and quality.

Potential new remedy

- 1.26 In an ideal world, the ability to procure on an efficient basis on the part of hospitals would be both incentivised and have a positive impact on consumers. We are concerned that this is not the case at present. To overcome these issues we propose an additional remedy. For a prescribed list of tests, scans and drugs, to be defined, insurers should have the right to make their own procurement arrangements from wholesalers of these products and services. Hospitals and clinics would then be required either to charge at the same rate as that secured by the insurer or to make use of the separate wholesale arrangement made by the insurer.
- 1.27 We believe this would very significantly, and more quickly, increase the level of price competition for these services to the benefit of the consumer. We consider that a remedy of this kind would also have significant positive effect where the

remedy of divestment, in particular outside of London, has been identified as being less effective since it would drive more competition even in those areas which remain served by a solus hospital or duopoly.

- 1.28 We are further concerned that there is great disparity in the hospital charging for a significant number of procedures (over 100) which are more commonly treated as outpatient procedures within the NHS, but for which we are charged routinely as more expensive Daycase procedures by private hospitals. We accept that there may be a proportion of such cases which do require to be carried out on a Daycase basis but we expect this proportion to be far lower than we currently experience. We believe this is another key area of customer detriment. We believe a remedy in this area could have significant and rapid effect to reduce cost for consumers. We are currently considering this topic further and will revert on this matter.

Other matters – legislation and enforcement

- 1.29 AXA PPP considers that for several areas of remedy there are existing pertinent areas of legislation (eg. consumer law), some of which may need some further strengthening. However AXA PPP believes there is critical requirement for the establishment of a strong and proactive regulator, akin to the Financial Conduct Authority in financial services, in order to ensure their enforcement and sustained application in the future.
- 1.30 We comment below in more detail on each of the remedy areas and address the questions raised by the CC.

AXA PPP's comments on the CC's possible remedies

2 Weak competitive constraints in many local markets, including central London

Remedy 1 - Divestiture of one or more hospitals and/or other assets in areas where competitive constraints are insufficient

Central London – the remedy would require HCA to divest a hospital or hospitals and other assets (the divestiture package) to a suitable purchaser or purchasers sufficient to impose a competitive constraint on HCA's remaining hospitals in central London. In considering the scope of the divestiture package that would be necessary to address the AEC our analysis took into account the range of the services provided by each of HCA's hospitals, their customer base, the volume of their private admissions and their turnover.

Issues for comment 1, central London

- 2.1 AXA PPP concurs with the CC's view that the most effective remedy that would address the significant AEC issues in London is to require HCA to divest a substantial part of its portfolio. We discuss the specifics of our recommendations below and offer a number of comments to support our reasoning.
- 2.2 As the CC has identified the AEC related to insured patients in central London has arisen as a result of HCA's ownership of six hospitals and interests in a

number of other facilities which are of a material impact on the market. This has resulted in HCA receiving a significant proportion of admissions and outpatient referrals in central London measured against its nearest competitor which is The London Clinic.

- 2.3 HCA negotiates prices across their portfolio of hospitals and as already represented to the CC there is no opportunity for an insurer to encourage hospitals in the HCA group to compete with each other – and HCA has understandably no motivation to do this.
- 2.4 AXA PPP believes that any remedy other than complete divestiture of particular properties and assets on HCA's part will not be an effective remedy. For example, an alternative remedy might be to require HCA to negotiate prices separately for each hospital and not require an insurer to recognise all facilities owned by HCA to gain a competitive price. This touches on the CC's Remedy 2 options. This remedy does not work. HCA knows that a PMI provider would have to include most of its hospitals in its network, and would simply price the hospitals accordingly to reflect the fact that if one HCA hospital is not included another has to be.
- 2.5 ✕ AXA PPP therefore believes that divestiture to a suitable purchaser is the only effective solution to the identified AEC – we comment further below under the specific questions about the definition of a suitable purchaser for divested assets because it could matter who acquired any divested hospitals or services.
- 2.6 AXA PPP believes that the greatest competition would arise in London if all the major, prestigious and previously defined 'must have' hospitals are owned by different groups. However, given HCA's existing position in London we have also been mindful of the proportionality criteria by which the CC is bound. Separate ownership of all HCA acute hospital facilities is therefore not the basis of our recommendation.
- 2.7 AXA PPP would first like to outline our strategy for London in the event that HCA divested facilities and therefore enabled alternative providers to develop services and compete with other London providers. In a theoretical example, AXA PPP believes that if hospitals in London were owned by 3 different operators, each of which on a stand-alone basis had a credible (defined below) proposition for customers, in particular corporate clients, we would be able to offer a range of compelling and competitive options. AXA PPP believes that having 3 groups of hospitals would enable us to negotiate attractive terms with one or more of the 3 groups for products that excluded the other groups/another group of hospitals.
- 2.8 The reasons for a requirement for three distinct hospital groups are both general and specific. In most markets, "3 to 2" mergers are rightly viewed with scepticism, because 2 firms are rarely enough for effective competition. In the present context, with 3 hospital groups serving central London with elite facilities, any one of these providers would be excludable, because it would know that a credible package can be assembled by combining the other two. This excludability is the defining criterion of competition over monopoly: if a hospital group cannot be excluded or bypassed to provide a particular type of product (eg. high end corporate PMI cover) its pricing is essentially unconstrained (except ultimately - as with all monopolists - by elasticity). By contrast, with 2 providers, there is a real possibility that a network comprising only one of them would

appear a little “thin”, and that as a result both of the two providers become ‘must have’.

2.9 Accordingly AXA PPP considers that having 3 credible groups is essential. We now discuss the essential ingredients of a credible group. Such a group of hospitals would need to include:

- A significant flagship hospital in central London
- Harley Street provision
- Coverage for a full range of specialisms
- High acuity cover
- A full cancer service including radiotherapy.

2.10 Currently the problem faced by AXA PPP is that any proposition, in terms of a London network that does not include any HCA hospitals, is simply not credible in the market. The only option therefore is to include all HCA hospitals (because this is the way HCA negotiates) which is then very expensive. ∞ If HCA is required to divest facilities in the manner outlined below, AXA PPP believes that it would be possible to create 3 groups of hospitals, each of which would be credible in its own right and attractive to cost conscious large corporate customers if presented in a ‘thin’ network. AXA PPP would also be able to negotiate with each of these groups separately and require them to offer terms against each other to secure inclusion into products.

2.11 AXA PPP would then be able to offer, amongst others, the following options:

Low Cost. A proposition that would include one of the three hospital groups in London. We anticipate that providers in this group would negotiate lower prices in exchange for being the only hospitals available to customers on this product and these prices would be passed on to customers as lower premiums. Customers would be willing to trade restriction of which hospitals they could use for lower premiums, with the assurance that their hospital network provided full coverage for all treatments and met their members’ expectations in terms of geographic coverage and reputation.

Mid Range Product. A proposition that would include 2 out of the 3 hospital groups in London. We anticipate that this would appeal to the majority of London based customers for whom price is not the primary, but nevertheless an important, consideration.

Full Hospital Coverage. This would include all, or almost all, hospitals in London and be priced at the premium end of the market. This would appeal to customers for whom price is not a consideration and who want their employees to be able to access treatment anywhere in London

2.12 AXA PPP has previously outlined its view that there are 7 elite hospitals in central London. HCA owns 6 of these 7 elite hospitals and negotiates the hospitals as a ‘block’, thus achieving a ‘must have’ status. As individual hospitals, if under separate ownership, the position would be very different and

AXA PPP believes this would give us a range of alternative options and opportunities.

- 2.13 As stated above, AXA PPP would propose 3 groups of hospitals in central London. Each group would need to include a major prestigious hospital supported by other London facilities offering additional services or geographic coverage. Each option would need to include private radiotherapy services. Whilst it is easy to see how individual hospitals can develop some additional services not currently provided in the relatively short term, the development of radiotherapy services is particularly costly, requiring capital investment and physical space which the majority of London providers do not currently have.
- 2.14 In creating a network offering, AXA PPP would need to be able to access private radiotherapy services in each of the 3 groups of hospitals it creates in London and so believes this needs to be factored in to divestment/investment decisions.

Flagship hospitals

- 2.15 Easily the 3 most significant hospitals in London by size, reputation and specialisms are:
- The London Clinic
 - The Wellington
 - The London Bridge

- 2.16 AXA PPP believes that each of the 3 groups of hospitals should have a ‘flagship’ London provider. Therefore, in AXA PPP’s view, these hospitals need each to be owned by different organisations, enabling AXA PPP to develop alternative network propositions with one of these providers – each containing a ‘premier’ or ‘lead’ hospital in London. This would mean that HCA is required to divest The Wellington or The London Bridge, neither of which could be acquired by The London Clinic.

Service gaps and Harley St presence

- 2.17 Given the current services and specialties covered by these facilities this would leave the following gaps which would need to be provided by other hospitals added to the 3 groups.
- Group 1 London Bridge Radiotherapy gap
 - Group 2 London Clinic Cardiac Surgery gap
 - Group 3 Wellington Radiotherapy gap

- 2.18 These gaps in services would be filled by adding additional hospitals that provide these specialties to the group in question. This is discussed further below.

- 2.19 In addition to being required to divest the London Bridge Hospital or The Wellington, AXA PPP would further argue that HCA should be required to divest one of its proximate Harley Street facilities, The Harley Street Clinic or the Princess Grace. Currently, HCA owns two of the largest hospitals in the Harley Street area, in addition to running the PPU at UCL which is also extremely close to Harley Street. This effectively restricts competition in this geographically critical location in London and prevents these hospitals from competing with each other.

- 2.20 In terms of reputation, a Harley Street location is synonymous with top quality and high end treatment and is a trusted healthcare brand. If HCA was required to divest one of these facilities it would enable The London Clinic, The Harley Street Clinic and The Princess Grace to compete with each other.
- 2.21 Currently the Princess Grace does not provide complex specialty services, such as Chemotherapy or Cardiac services, although it does have an ITU, because HCA has alternative hospitals which provide these services. AXA PPP would anticipate that if the Princess Grace were in a position where it needed to compete for patients with the other key Harley Street facilities (The London Clinic and The Harley Street Clinic), it would have strong reasons to invest and develop, for example, cardiac and oncology services and would then be able to compete with the more highly specialised providers in Harley Street locations.
- 2.22 However this is not the position with radiotherapy, which would need to be created by the remaining/new owner of the Wellington. AXA PPP believes that it would in practice be more difficult for a new entrant to create this and therefore it is likely that such a transition is best effected by the incumbent. Transitional arrangements so that services continue to be made available on specified terms should be considered in the interim.
- 2.23 As it is already a key competitor in the Harley Street area, The London Clinic should not be allowed to acquire whichever of The Harley Street Clinic or The Princess Grace was divested, in order to give three competing options in the proximate Harley Street area. AXA PPP would then anticipate the following hospital groupings:

	Group 1	Group 2	Group 3
Lead Hospital	London Bridge	London Clinic	The Wellington
Harley Street	PG or HSC	N/A	PG or HSC

- 2.24 In summary, for the reasons given above, AXA PPP argues that requiring HCA to divest the following hospitals would bring significant competition to London, enabling AXA PPP to negotiate lower prices with providers which would have to compete for groups of customers and lower prices for private insured members in London, provided that neither of the divested hospital are acquired by The London Clinic:
- The Wellington or The London Bridge, and
 - The Harley Street Clinic or The Princess Grace
- 2.25 We have explained our thinking in theoretical context of 3 separate providers. This would give AXA PPP and other insurers a range of options in constructing credible networks for customers in conjunction with some or all of the next tier, 'non elite' providers. There would in practice be many other permutations, however we believe that the above divestments are essential at a minimum. This gives the opportunity to create three groups of hospitals, each of which could provide a credible proposition for customers on a stand-alone basis. Each group would include a flagship London hospital as the 'lead' provider supported by a Harley Street hospital, with only one group owned by HCA. AXA PPP

believes this would create competitive negotiation with the hospitals included in each group, offer customers a range of options to buy either 1, 2 or 3 of the groups each of which would deliver a compelling proposition, thereby opening the London market to additional customers.

2.26 Further considerations:

a) *The Portland*

2.27 The Portland has a dominant position based on its specialism in Obstetrics and Gynaecology and its geographical location near to Harley Street. Currently HCA has the ability to use the Portland's status (as a 'must have' Obstetrics and Gynaecological facility) as leverage in negotiations with its other hospitals. This leverage is reduced in the event that HCA divests other key London facilities but AXA PPP would recommend that consideration should be given to requiring HCA to

b) *Primary Care Facilities*

2.28 Currently HCA owns the two largest and most prominent private primary care facilities in London, being Roodlane and Blossoms Inn and in addition a third provider, General Medical Clinics. All three of these providers have a significant number of key corporate customers in London for whom they provide a range of services including private GP services, outpatient diagnostics and Occupational Health. These providers are therefore very influential in determining how patients receive treatment, who they receive treatment with, and in which facilities.

2.29 The CC has noted that these vertical relationships between HCA and GP practices do not appear to have influenced referral rates as these have remained similar pre and post-acquisition by HCA. However, AXA PPP continues to believe that since HCA has such a dominant position, it was already going to command a high proportion of the referrals made by these primary care providers. These relationships would become much more important to HCA if they owned fewer hospitals.

2.30 AXA PPP does not support, in principle, the ownership by hospital groups of any primary care provision. This situation is made all the more worse from a consumer perspective where:

- 1 there is a high concentration; and
- 2 this 'tied' ownership is also not made clear such that it is presented to the consumer as an independent facility.

2.31 AXA PPP would argue that vertical integration has at least the potential to drive a perverse incentive in the market for a primary care provider to favour secondary and tertiary care providers in the same group. Given HCA has limited competition, in particular in the corporate client market for primary care services, AXA PPP therefore believes that primary care facilities should form part of the divestment package and that HCA should be required to divest as a minimum, one of Roodlane or Blossoms Inn, being the most significant private primary care providers in London. If this does not happen AXA PPP believes that HCA will simply set up arrangements whereby its vertical providers make substantial referrals to their retained facilities.

c) *Leaders In Oncology Care (“LOC”)*

- 2.32 LOC is a ‘leading team of 50 world class consultants and specialists in all aspects of oncology’⁶ owned by HCA International. It provides care for a significant proportion of oncology referrals in London (according to high level AXA PPP analysis of 2012 data \times % of treatment measured by spend in central London is provided by a LOC consultant) and as such is responsible for the care pathways of a significant number of patients who receive their treatment in London.
- 2.33 AXA PPP considers that such an organisation should be independent of any features that might or do influence their referral patterns and the decisions they make on treatment on behalf of patients. Despite its and HCA’s position on ownership it is possible to see a scenario whereby \times (which are subject to a significant mark up by HCA) and for treatment, the costs of which are the highest in London.
- 2.34 AXA PPP therefore concludes that HCA should be required to divest LOC which should not be acquired by another hospital or hospital group but should be an independent organisation if still remaining a group.
- 2.35 In response to the questions raised by the CC:
- (a) Would a divestiture remedy address the AEC in central London effectively and comprehensively? Are the criteria that we have set out for specifying a divestiture package appropriate? If not, what criteria should we use to specify the divestiture package and what assets should be included in it?***
- 2.36 As explained above AXA PPP does believe that a divestiture remedy would address the AEC in central London. We believe that HCA needs to be required to divest a minimum of two hospitals, either The London Bridge or The Wellington and, either The Harley Street Clinic or The Princess Grace, none of which should be acquired by The London Clinic. AXA PPP believes this would enable AXA PPP to work with 3 groups of hospitals in central London, each of which would comprise a credible and marketable network proposition in their own right, including a central London flagship hospital, Harley Street provision and which would cover all specialties and acuities, including radiotherapy.
- 2.37 AXA PPP also believes that separating ownership as described above would potentially further encourage particular hospitals to invest and diversify specialisms which would add further contestability in to the London market. Currently for example, The Princess Grace and The Harley Street Clinic have no incentive to compete with each other, in fact they have a reverse incentive and this will only change if there is a forced change in ownership.
- 2.38 We have no further comments on the criteria the CC has specified in its divestiture package. In the event that HCA is required to divest particular facilities this should include all assets associated with the facility divested.
- (b) Are there suitable purchasers available with the appropriate expertise, commitment and financial resources to operate and develop the***

⁶ Source: HCA International website

divestiture business as an effective competitor without creating further competition concerns? Would the remedy be effective only if the entire package were divested to a single owner or would ownership of the divested business by two or more purchasers address the AEC effectively?

2.39 AXA PPP believes it is more appropriate for the providers to comment on the first part of this question. The answer would potentially be dependent on which hospitals and other assets in London are divested and other divestiture decisions nationally. For example, if BMI was not required to divest hospitals proximate to London, AXA PPP may be concerned if it was allowed to purchase Central London provision. This might alter if BMI had to divest proximate London provision.

2.40 As we have argued above AXA PPP believes that the most effective way to address the AEC is to separate ownership of the hospitals divested. Therefore, in the proposal put forward by AXA PPP, we would propose the following.

- That HCA be required to divest The London Bridge Hospital or The Wellington. Neither hospital to be acquired by The London Clinic being the third flagship hospital (in addition to The London Bridge and The Wellington) in London.
- That HCA be further required to divest one of its proximate Harley Street facilities to enable a further provider to add competition in the prime Harley Street location, which are The Harley Street Clinic or The Princess Grace Hospital. Neither facility should be acquired by the London Clinic which, if allowed, would have the effect of simply creating another dominant provider in the location. Currently, with HCA owning both facilities (and running UCL) there is no incentive for the facilities to compete with each other for referrals on any measure including service, quality and price. This would give another provider the opportunity to offer a competitive proposition in a Harley Street location and potentially make investments to develop additional services if required.
- That further considerations should be made in respect of permitting & The Portland hospital, the inclusion of HCA's larger primary care facilities as part of the divestment package and the establishment of LOC as an independent organisation.

(c) Would a divestiture remedy on its own be sufficient to address the AEC or would additional measures be required to ensure a comprehensive solution? Would, for example, the remedy be liable to circumvention through arrangements with consultants that would result in them conducting their private practice wholly or predominantly at HCA's remaining hospitals? Are there other ways in which HCA could circumvent a divestiture measure?

2.41 We have argued above and separately in this response that we do not believe a divestiture remedy on its own would be sufficient to address the AEC in total, in particular if this only applies to the acute hospitals in the HCA group. AXA PPP argues that as a minimum HCA should be required to divest one of their primary care facilities of Roodlane or Blossoms Inn. In addition they must divest LOC given its dominance in London and its criticality in taking decisions for their

patients that should not be able to be influenced by ownership arrangement or other financial incentives no matter how these are presented.

- 2.42 Further to this point, to prevent HCA and indeed potential new owners of facilities in London from influencing patterns of referrals which could have the effect of distorting competition, all specialist incentive and ownership arrangements need to be banned. This is covered separately by the CC and we comment further in the relevant section.

(d) Are there other assets or businesses, besides hospitals and their out-patient facilities, which it would be necessary or appropriate to include within a divestiture package? These could be physical assets, such as consulting rooms, or, for example, they could be joint ventures with others or NHS contracts to operate PPUs. Would divestiture of any such assets or businesses present particular problems?

- 2.43 AXA PPP was not supportive of HCA's successful bid to run the private cancer unit at Guy's and St Thomas' NHS Foundation Trust. AXA PPP believes that HCA should divest this contract because Guy's can clearly offer competition to The London Bridge which currently, in the private provider market, has a somewhat unique and privileged position being the closest flagship hospital to both the City and Canary Wharf, and with current 'solus' status in this area. Referrals to this facility have increased significantly in recent years as more large corporates in the UK have moved their head offices to Canary Wharf.

- 2.44 AXA PPP believes that PPUs have the opportunity to offer significant competition to private hospitals, albeit that there are constraints, for example because a number of services are shared with the NHS. PPUs, particularly in London, often have access to high acuity services and potentially lower cost diagnostics and consumables than stand-alone private hospitals. These dynamics should mean PPUs are able to compete effectively on price, whilst also offering access to high acuity facilities.

- 2.45 However, the PPUs will not compete effectively with the private providers where those providers constitute the management of the PPUs in question. Given HCA already runs the PPU at UCL, AXA PPP believes it should be prevented from bidding for other PPU opportunities in London and should be removed from its involvement in Guy's and St. Thomas'. Further any new owner of the London Bridge should be debarred from Guy's as well, as currently this new PPU is the only potential local competition to the London Bridge hospital.

(e) Would divestiture of an HCA hospital or hospitals and/or other assets confer market power on the acquirer? In what circumstances might this risk arise? Are there hospitals or other assets whose divestiture would be particularly likely to give rise to this risk?

- 2.46 AXA PPP has commented on this point further above, reasoning that The London Bridge, The Wellington and The London Clinic each need to be separately owned. HCA must also be required to divest one of its Harley Street facilities. In addition The London Clinic would not be able to acquire a further Harley Street hospital.

- 2.47 As noted above separate management of London Bridge and Guy's and St Thomas' is required.

2.48 In addition we have highlighted that further consideration should be given to the Portland hospital, the divestment of major central London primary care facilities (Blossoms Inn and Roodlane) and LOC.

2.49 Further extension of BMI's presence in south east London could present an issue. We will consider this in light of the CC's list of hospitals for potential divestment.

(f) How long should HCA be given to effect the sale of the divestiture package? Our guidelines state that in relatively straightforward divestiture cases a maximum period of six months is appropriate. Is that sufficient in this case?

2.50 AXA PPP has no particular comment on this point but would support the timescales being relatively short, balanced by needing to be reasonable. It is important that a relatively short timetable is achieved in view of the fact that it is AXA PPP's belief that divestiture is the only effective remedy to address the significant AEC in London and should be implemented as soon as practicable.

(g) What are the relevant costs and benefits that we should take into account in considering the proportionality of the divestiture options?

2.51 We would underline the critical importance of this remedy and can think of no plausible reason why transaction costs should be so unreasonably high that they would be disproportionate to the positive impact on competition of the remedy.

(h) Are there other remedies that would be as effective in remedying the AEC that would be less costly or intrusive?

2.52 AXA PPP believes that divestiture is the only remedy for the identified AEC in London - in fact AXA PPP believes that significant divestiture by HCA of assets is the only remedy that would have an effective term effect on the AEC. As argued above this also needs to be implemented in conjunction with removing consultant incentives and HCA should be prevented from managing any other PPU's in London. The CC has identified AECs in central London deriving from the market concentration of HCA. Price controls are not a feasible remedy and are, in any case, a poor substitute for the structural remedy outlined above, which would create a properly competitive market.

Issues for comment, 1, outside central London

2.53 Before dealing with the specific questions raised, we have a number of observations on the general position. We broadly concur with the CC's provisional findings as to the key characteristics of the market, in particular:

1. that the market outside London is dominated by the key national hospital groups;
2. that each group has solus providers in a number of areas; and
3. that there may be clusters of hospitals where a particular provider has market power.

2.54 At this point we have not seen the detailed results of the CC's analysis. We do however note that the methodology which has been employed appears to be

more suited to the self-pay market. From the perspective of an insurer, the bargaining power of a hospital group may also depend not just on the number but also the proportion of hospitals in that group which have ‘must have’ status. This status may be the result of being a solus hospital, being part of a cluster, or as a result of strength in a key specialty in a local market.

- 2.55 AXA PPP highlights the proportion of ‘must have’ facilities since the main form of countervailing bargaining power available to insurers faced with a hospital group with a number of must-have facilities involves bargaining over inclusion, or the terms of inclusion, in more competitive areas. The maintenance of this form of countervailing power is critical given that no remedy is available materially to reduce the number of solus areas.

The remedy would require BMI and Spire to divest one or more hospitals (the divestiture package) in those local areas with Clusters to a suitable purchaser. In considering the scope of the divestiture package we have taken into account the nature of the services provided by the hospitals, their location, their mix of patients and their volume of private admissions.

(a) Would a divestiture remedy address the AEC effectively and comprehensively? Are the criteria that we have set out for specifying a divestiture package appropriate? If not, what criteria should we use to specify the divestiture package and what assets should be included in it?

- 2.56 As stated in previous submissions, and consistent with the above, while all the hospital groups have some areas where they are the solus provider, this is, in most cases, broadly counter balanced by them wanting to have as many of their facilities recognised as possible by insurers. In our experience this has mitigated against providers charging significant amounts in areas of solus provision and only pricing competitively in areas where there are effective constraints.

- 2.57 Outside of London, although we agree that BMI and Spire may have a greater degree of market power in some geographical regions, we do not currently experience the same level of disadvantage that we do with HCA in London. We are sceptical in the round of a remedy that requires BMI and Spire to divest hospitals. However we are open minded to the CC’s approach and will review the potential hospital divestitures identified by the CC to consider the potential implications.

(b) Are there suitable purchasers available with the appropriate expertise, commitment and financial resources to operate and develop the divested hospitals as effective competitors without creating further competition concerns?

- 2.58 Once we have seen the list of potential divestments, we will be able to comment on the suitability or otherwise of any sale to an existing market participant. We understand that some foreign operators review the market from time to time, but are unable to comment at this stage on the likely attractiveness of these hospitals to them.

(c) Would a divestiture remedy on its own be sufficient to address the AEC or would additional measures be required to ensure a comprehensive

solution. Would, for example, the remedy be liable to circumvention through arrangements with consultants that would result in them conducting their private practice wholly or predominantly at the divesting hospital operator's remaining hospitals? Are there other ways in which BMI or Spire could circumvent a divestiture measure?

2.59 The comments AXA PPP has already made about London relative to this question are relevant also to this answer. A total ban on incentive arrangements including ownership models would be required to ensure the providers were unable to circumvent a divestiture measure. This is particularly important given the fact that the existing owner of a hospital will have a relationship with the consultants who currently refer to that hospital. The incumbent would potentially be able to use this relationship prior to a divestiture to make arrangements with particular consultants to alter referral patterns going forward. It may be very difficult for the acquiring provider to counteract or even discover such arrangements.

2.60 This issue further underlines the necessity for ensuring that all forms of incentive, without exception, are banned.

(d) Are there other assets or businesses, besides hospitals and their outpatient facilities, which it would be necessary or appropriate to include in a divestiture package? These could be physical assets, such as consulting rooms, or, for example, they could be joint ventures with others or NHS contracts to operate PPUs. Would divestiture of any such assets or businesses present particular problems?

2.61 Divesting hospital groups should be required to divest all assets associated with a given hospital including outpatient facilities otherwise they will retain the ability to direct referrals to themselves in a slightly different location. In addition, for any given market hospital arrangements with local GPs (if in existence) would need to be reviewed. AXA PPP does not have knowledge of whether such arrangements exist.

(e) Are there particular assets whose divestiture would confer market power on the acquirer? To avoid creating further competition concerns would it be necessary to exclude certain assets from the sale?

2.62 We have no further comments at this time.

(f) How long should BMI and Spire be given to effect the sale of the divestiture package? Our guidelines state that in relatively straightforward divestiture cases a maximum period of six months is appropriate. Is that sufficient in this case?

2.63 AXA PPP has no particular comment on this point but would support the timescales being relatively short, balanced by needing to be reasonable.

(g) What are the relevant costs and benefits that we should take into account in considering the proportionality of the divestiture options?

2.64 We have no comment at this time.

(h) Are there other remedies that would be as effective in remedying the AEC that would be less costly or intrusive?

2.65 We have no comment at this time.

Remedy 2 - preventing tying or bundling

We provisionally found that BMI, HCA and Spire have market power in negotiations with PMIs.

The aim of this remedy is to prevent BMI, HCA and Spire from using their market power in certain local areas. We considered two variants of this remedy.

The first, (2a), would seek to prevent BMI, HCA or Spire from raising its prices nationally if a PMI changed its network policy such that patient volumes to the hospital operator concerned were likely to fall. This might occur if, for example, the PMI chose to remove one of the operator's hospitals from its network or if it added a rival hospital to its network. In neither case would the private hospital operator be entitled to raise its prices nationally in response.

2.66 This is a complex area and we are concerned about unintended consequences of any solution. In summary our view is that:

1. Whilst it is arguable that there may be an issue outside of London, it is not in our view of the same magnitude as the core issues of central London and the use of incentives.
2. An essential feature of the market, namely the existence of a substantial number of local monopolies, cannot be remedied. In those circumstances it is particularly important that insurers maintain the widest possible range of commercial strategies. Insurers use competitive areas as a means of limiting prices in solus areas. The banning of tied/bundled contracts runs a significant risk of blunting this strategy. This may give rise to consumers losing out in one area with no real guarantee of benefits to consumers elsewhere.
3. Hospital operators are very keen to maximise their revenue across their whole network, and this gives insurers the countervailing bargaining power exercised through the development of networks. In these cases insurers secure discounts in return for \times access to its customers. We see the judicious use of such arrangements as being to the benefit of customers rather than their detriment. Such arrangements may be materially or even fatally undermined by the imposition of a ban on tying/bundling, and would render insurers, and ultimately their customers, exposed to the full force of local monopolies without available countervailing measures. The CC recognises that PMIs have some countervailing power against hospitals. It would be entirely counter-productive if, in the guise of constraining hospital market power, the CC was in any way to weaken what countervailing power is currently achieved by PMIs.
4. We also question the efficacy of such a ban. Although no doubt it would prevent the automatic application of a disproportionate immediate penalty, at the next annual renewal there is little doubt that a hospital operator would

seek to achieve redress. Knowledge of this fact would still give the insurer pause.

- 2.67 We do however recognise that there may be specific circumstances where intervention would be helpful. The first of these is where a hospital group imposes a blanket ‘one in, all in’ strategy. For clarity we have only experienced this in central London. We see merit in a remedy to prevent the adoption of such an extreme position.
- 2.68 We are also conscious that a deal based on exclusive, privileged or even partial access to customers in an area, although negotiated as part of a competitive package, and securing discounts that ultimately benefit end-customers, may have the unintended consequence of hampering, more likely temporarily rather than permanently, a new entrant. To be clear, we see this as a “theoretical” risk and have seen no evidence that it has occurred in practice. For the avoidance of doubt, as we have previously stated to the CC, when Circle sought to enter the market in Bath, BMI did not, and did not threaten to, increase prices in other areas. However AXA PPP has no interest or incentive to deter pro-competitive entry. That said, AXA PPP considers that the concern raised, such as it is, can be fully addressed by a less intrusive remedy. We would suggest a carve out, such that new entrants (both ab initio and extensions of existing hospitals) should be subject to a carve out in relation to deals based on access to customers. This would require a tendering process in, and restricted to, the local area in question, and prevention of price changes elsewhere as a consequence.
- 2.69 To give a specific example there is a new hospital opening in October 2013 in Bristol owned by Nuffield. AXA PPP is currently running a tender in this location enabling Nuffield to present their terms and also giving the existing provider the opportunity to respond. Both providers will be given the opportunity to provide us with terms for being a joint or solus provider and we reserve the right to accept one or both proposals. We also reserve the right to remove the incumbent provider (Spire) from our hospital lists if the offer from Nuffield is compelling.
- 2.70 We would suggest that were Nuffield to succeed, either on a solus or joint recognition basis, that any separate agreement with Spire based on privileged access to customers would not apply. The effect would be that prices from Spire for their Bristol hospital could change but those elsewhere could not. Indeed, whereas the price change in Bristol would reflect the fact that Spire no longer obtained the level of customer access on which their original price offer had been predicated, a price change elsewhere (where the degree of customer access has not changed) would have the flavour of a retaliatory action designed to deter AXA PPP from recognising efficient entrants.
- 2.71 In response to the CC’s questions:
- (a) Would this remedy be effective? Would hospital operators be able to deter PMIs from removing hospitals from their network or recognizing a local rival in ways other than by raising or threatening to raise prices in response?***

- 2.72 As discussed above the remedy would remove the automatic, contractual imposition of a general price increase in response to local changes. However at the next annual price negotiation the hospital group would still seek to exercise its market power. Given that this market power is unchanged it is difficult to see the practical outcome being any different, albeit potentially delayed.
- 2.73 Additionally we believe there is significant risk of unintended consequences in relation to this remedy in the proposed form.
- 2.74 However we see merit in more limited changes as outlined above.
- 2.75 Further we have proposed in section 1 above a new remedy for consideration concerning procurement which we believe would have strong effect to stimulate price competition to the benefit of the consumer.

(b) How quickly would this remedy come into effect? Would it be necessary to wait until existing contracts with PMIs had come to an end to implement it or could this process be accelerated, and if so how?

- 2.76 Although AXA PPP operates with framework agreements which may extend for several years, there is provision for annual review. We believe therefore that once the remedy is made final, a reasonable period for implementation would be circa 12- 18 months according to the renewal cycle of the agreements.

(c) Is the remedy reasonable? Might a hospital operator have appropriate grounds for seeking a price increase from a PMI in the event that it reduced the amount of business it did with the operator? What economic rationale would there be for a cross-operator (rather than single hospital) volume discount, for example?

- 2.77 We have no contracts in place which are directly related to \times . We do however seek to secure discounts, for the benefit of our customers, based on \times in particular areas. We believe that it is reasonable for a hospital operator to remove a discount which has been agreed based on \times , should that access be amended. However to the extent that this might be thought to impede a new entrant to the market we have suggested an appropriate carve out to cater for these circumstances.

(d) Would it be necessary to provide for continuous monitoring of the remedy and/or to establish a mechanism for adjudication in the event of disputes? If it would, which would be the most appropriate body to undertake these functions and how should it be funded? What would be the expected costs of monitoring?

- 2.78 We are not convinced that such intervention in the market is required at this stage. We may comment further when a final remedy, if any, is clearer.

(e) What other measures would be necessary to prevent circumvention of the objectives of this remedy?

- 2.79 AXA PPP does not believe other measures are necessary other than those outlined in our responses above.

Remedy 2b would require BMI, Spire and HCA to offer and price their hospitals separately and individually to PMIs. It rests on the assumption that in these circumstances the hospital operator would charge lower

prices in competitive areas but would either raise them elsewhere (thus encouraging new entry) or be deterred from doing so by the threat of new entry or by reputational risk and would accept lower margins overall.

2.80 AXA PPP believes this remedy is not required and in indeed has the potential for negative consequences.

2.81 As noted above our view is that:

- 1 It is not clear that existing pricing arrangements have in fact acted as an impediment to new entrants.
- 2 An essential feature of the market, namely the existence of a substantial number of local monopolies, cannot be remedied. In those circumstances it is particularly important that insurers maintain the widest possible range of commercial strategies. Insurers use competitive areas as a means of limiting prices in solus areas. The imposition of purely local pricing runs a significant risk of blunting this strategy. This may give rise to consumers losing out in one area with no real guarantee of benefits to consumers elsewhere.
- 3 Hospital operators are very keen to maximise their revenue across their whole network. This can be leveraged by insurers through the development of networks. In these cases insurers secure discounts in return for exclusive or privileged access to its customers. We see the judicious use of such arrangements as being to the benefit of customers rather than their detriment. Such arrangements may be materially or even fatally undermined by the imposition of purely local pricing.
- 4 We also question the efficacy of purely local pricing. Although no doubt it would prevent the automatic application of a disproportionate penalty, at the next annual renewal there is no question that a hospital operator would seek to achieve redress. Knowledge of this fact would still give the insurer pause.

2.82 In response to the CC's questions:

(a) Would this remedy be practicable? Would the scale and complexity of negotiating prices on an individual hospital basis be sustainable?

2.83 AXA PPP does not believe that this remedy would be practicable or is required for the reasons mentioned above. As a one off exercise it would take significant effort. As alluded to in the question, it would take significant resource, not just to do the one off exercise but also to ensure contracts are maintained on an on-going basis.

2.84 In addition AXA PPP has complex network arrangements with providers in the UK. It has the following

- Main network which includes the majority of acute hospitals in the UK (but not all)
- Health on Line
- Corporate Pathways

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2.85 AXA PPP believes this would be as impracticable for providers as it would be for AXA PPP.

2.86 As noted above AXA PPP proposes a new remedy outlined in section 1 for consideration.

(b) How quickly would this remedy come into effect? Would it be necessary to wait until existing contracts with PMIs had come to an end to implement it or could this process be accelerated, and if so how?

2.87 If implemented (which AXA PPP does not advocate) this would require significant lead time as there would probably be IT implications for both parties and it would take substantial planning. It would completely change the way negotiations are currently conducted and could mean that negotiations would have to occur location by location so that all potentially competing hospitals in a geographic location were negotiated on the same time scales which would add significant complexity to group contracts which currently have a start and end date that is applicable to all hospitals in the group.

2.88 It would have to be done on a staggered basis (given the enormity of the task) and would require significant resource.

2.89 The remedy, in AXA PPP's opinion would have to wait for existing contracts notice periods to end because, to negotiate competitively at a local level and gain leverage from market forces insurers would have to be able to remove a hospital in the event that they simply cannot agree a competitive tariff. This would of itself raise a number of issues because the parties would need to continue to do business with each other in the time between existing contracts coming to an end and new local contracts being arranged.

2.90 This in turn could potentially cause significant disruption to established network and customer propositions.

2.91 Further this would also have a knock on impact to an insurer's pricing, especially in solus areas, which is likely to have an adverse effect on customers.

(c) If practicable, would it be effective? To what extent could reputational risk be relied upon to deter price increases in Single hospital areas?

2.92 AXA PPP does not believe it would be effective. It is likely that whilst each hospital contract would look different on a hospital by hospital basis, the totality of all contracts (when added together) in a group would most likely be the same. In any event, this is what providers will seek to do. In all negotiations where AXA PPP has sought to renegotiate financial terms for a particular item (because for example the price being charged is out of alignment with other providers or current medical practice), or has sought to normalise tariffs across a group (because for example the number of tariffs has become unwieldy following acquisitions) providers have sought to do so on a cost-neutral basis. This is a constant theme in negotiations and AXA PPP does not anticipate that requiring hospitals to negotiate on a case by case basis would change this position overall. We have raised this in previous submissions.

- 2.93 How much this would be constrained by reputational risk is unclear, as it is unclear what the reputational risk would be. In respect of reputational risk this falls at least as much on the insurer. Controlling supplier prices is perceived as one of our key functions by our customers, hence failure in this regard will affect us at least as much as the hospital if not more so.

(d) If prices were raised in Single hospital areas how confident could we be that this would lead to new entry and over what time period? Would this depend on the size and attractiveness of the local market concerned, for example the number of PMI subscribers or corporate scheme members in the hospitals' catchment areas?

- 2.94 We are concerned by the premise of the question. We do not believe that a new entrant guarantees a price reduction. Indeed our view is that cost increases are more likely as competition for consultants (and thereby patients) can lead to incentives/gold plating of services resulting in higher prices. The enthusiasm for incentives, specifically in competitive areas, underlines the strong motivation of hospitals to maximise the number of patients and the revenue per patient. Whilst we anticipate that the worst examples of this behaviour will be curbed by the banning of incentives, the underlying approach is likely to remain.

- 2.95 It should also be noted that the competitive effect is not so significant. As the CC has pointed out duopoly situations are far from perfect, and this duopoly is the best outcome that is likely to be achieved.

- 2.96 Furthermore, any new entrant may not emerge, or be delayed by planning or similar obstacles and there is no guarantee that they would provide a full range of services. A duopoly of 2 'must haves' is potentially the worst possible outcome from an insurer's, and hence a consumer's, perspective.

e) Is it likely that this remedy would have unintended consequences? For instance, would it be likely to lead hospital operators to close hospitals and if they did would this result in consumer detriment?

- 2.97 In the context of the comments made above this remedy, especially in a stagnant market, will only be effective if hospital operators close inefficient, poorly performing hospitals. As a generalisation, hospitals have done little over the years to drive up efficiencies or drive down costs. There has been little new provision in reality and hospitals have not had any encouragement to redefine and develop their operational models and as explained above expecting insurers to in effect guarantee their income for them. New provision and the threat that hospitals will compete and take business from them should stimulate the market.

- 2.98 This will not have consumer detriment if the new hospital is geographically close enough to the incumbent and can provide the same range of services. This latter point is a potential risk if the new hospital does not have the same range of specialities as the existing provider which is the situation for example.

- 2.99 However, if a new entrant causes an incumbent to close, the new entrant becomes the solus provider and over time could potentially seek to use this position to increase prices

(f) Would hospital operators be able to frustrate the aims of the remedy by entering into arrangements with consultants that would prevent or deter them from practising at an entrant's hospital? Could hospital operators deter or delay PMIs' recognition of an entrant?

- 2.100 AXA PPP's response to this is that this is probably so. Removing incentives to consultants in any form they take, which we discuss further below, will go some way to mitigate against this risk. It will be more difficult for a hospital to persuade consultants to behave in a particular way if they are unable to offer a financial incentive to encourage them to do so.
- 2.101 Hospitals could make it a requirement of conferring admitting rights on a consultant that the consultant had to bring all appropriate (from a medical perspective) referrals to their facility and consultants can choose whether or not to accept terms.
- 2.102 In addition we would expect a new entrant to develop a facility that consultants will want to work at – attracting them with modern equipment and smart facilities.

Remedy 3 - restrictions on expansion

This remedy would work by preventing the owner of a hospital in a Single or Duopoly area from partnering with an NHS Trust to operate a PPU. Measures to implement this remedy would be directed at hospital operators in the areas of concern that we have identified.

- 2.103 AXA PPP is supportive of this remedy. AXA PPP believes that if set up and run appropriately PPUs are able to offer some competition to stand-alone private hospitals. As we have discussed above, PPUs have a strong potential proposition given the back-up services they are able to offer and can be attractive for consultants who do not wish to travel to another hospital. To offer a suitable alternative proposition a PPU would need to provide dedicated accommodation for private patients to enable it to compete effectively, but aside from that they have many other advantages in terms of their cost base and buying power for consumables in order to develop an attractive offering. We would expect prices charged to reflect these facts and therefore be competitive against other private provision.
- 2.104 As identified by the CC, developing new or under-performing PPUs could be a cost-effective way of new provision entering a market and providing contestability in Single and Duopoly areas. By definition this contestability will not be achieved if the existing owner of the Single or Duopoly hospital becomes the manager of the new unit. If this were allowed we would expect the new owner to seek to impose their charging structure on the new PPU which would be resisted but may be difficult to negotiate against in reality. Whilst a supplier may have an interest in taking over, developing and managing a PPU close to one of their private hospitals to expand in the location, the objective for their interest is likely to be equally motivated to ensure that there remains no competition to their facility. Thus AXA PPP supports this remedy.
- 2.105 In response to the CC's questions we comment as follows.

(a) Would the remedy be effective? In how many and which Single or Duopoly areas is it likely that PPUs will be launched?

- 2.106 As stated above AXA PPP believes this is an effective and necessary remedy. AXA PPP believes that an existing provider would potentially have an interest in developing and managing the PPU close to one of its hospitals, at least partly motivated to ensure competition does not enter the local market, if this remedy was not implemented. AXA PPP believes that a properly developed PPU with dedicated private accommodation facilities can offer effective competition to private provision. This would not be the case if the PPU was managed by an existing supplier which we would expect to seek to charge in accordance with their existing tariff. Whilst this would be resisted the PPU will have knowledge of the prices being paid by insurers in the market which it would use to its advantage.
- 2.107 AXA PPP believes that the market will see an increasing number of NHS hospitals wanting to develop private facilities and there is evidence of this in central London – which also has been largest opportunity. The trend has been towards outsourcing the development and running of these facilities to third party providers, although this need not be the case. We note that the McIndoe Surgical Centre in East Grinstead, where the PPU is currently managed by BMI, has recently announced that it will take over the running of the unit itself regaining control from BMI. The trend of outsourcing to private providers is understandable and this in turn could help PPUs develop and be up and running more quickly than they otherwise could have achieved if the development and management was the responsibility of the NHS trust.
- 2.108 In terms of the number that we anticipate will be developed in Single and Duopoly locations, this is not possible for AXA PPP to comment.

(b) How practicable would it be for other hospital operators to form PPU partnerships in areas where they did not already operate a hospital?

- 2.109 This is clearly for the hospital providers to comment on but AXA PPP would be surprised if this was a constraint for them. The main hospital operators have national propositions in the main and there are examples where PPUs are run by providers who do not also own the local private hospital.

(c) Would the remedy give rise to unintended consequences or distortions? Would NHS Trusts suffer because they would be unable to partner with an incumbent hospital operator which could offer a financially more attractive arrangement than an entrant?

- 2.110 One of the main reasons an incumbent would be able to offer a financially more attractive arrangement than an entrant would seem to be because they would determine value from not allowing another provider to enter the market to compete with them. Therefore they would be willing to offer a more substantial financial package. We believe this reinforces the argument for implementing the remedy.
- 2.111 We believe the NHS is not, and should not be, exempt from competition regulation in respect of its activities in the private sector. It is hard to justify any entity exploiting pricing power whether in the private or public sector or a combination. The CC should not provide a carve out to permit it.

(d) Would customer detriment arise if the incumbent was prevented from partnering in a PPU but no entrant appeared?

- 2.112 This could be a potential consequence if the NHS Trust did not want to continue running the PPU within its own structure and the PPU was forced to close. However, AXA PPP believes that the impact on customers would be limited since the number of PPUs outside London that have been developed and have an existing incumbent is reasonably few.

(e) What provisions would need to be made for oversight and enforcement of this remedy and which body should be responsible? Would it, for example, fall within Monitor's remit?

- 2.113 Our experience at present is that the respective responsibilities of the OFT and Monitor are not well defined. Clarification on this point would be helpful.

3 The existence of incentive schemes operated by private hospital operators to encourage patient referrals for treatment at their facilities

Remedy 4 - preventing hospital operators from offering to consultants any incentives, in cash or kind which are intended to or have the effect of encouraging consultants to refer patients to or treat them at its hospitals except where such ownership results in a reduction in barriers to entry that is likely to be at least as beneficial to competition as any distortion is harmful

- 3.1 We believe there is good evidence that incentives produce significant effects on the behaviour of the average doctor not just at the margins. Indeed at the margins there is evidence that incentives can produce extremely damaging behaviour.
- 3.2 In our view a ban on incentives should also cover *any arrangement having the effect of a financial incentive*. By this we mean that this ban should be extended to prohibit doctors' equity in units into which they refer patients for treatment.
- 3.3 In our previous submissions, we highlighted a study in the Journal of the American Medical Association (roughly the equivalent of the British Medical Association in the UK) which showed that the propensity of doctors to order treatments was increased by seven times when they could claim a fee and over twelvefold where the doctor also owned the facility⁷. This is not an isolated finding.
- 3.4 A study published in 2010 in another leading journal from American Medical Association JAMA Surgery (previously known as Archives of Surgery) analysed 5 years of claims data from a large insurer in Idaho and compared intervention rates in procedures which could be performed in day-case theatres by surgeons who owned such facilities and those who did not. The age and sex adjusted odds ratio showed consistently that intervention rates were higher in the

⁷ Association Between Physician Billing and Cardiac Stress Testing Patterns Following Coronary Revascularization: JAMA. 2011;306(18):1993-2000

- ownership group. This was by 54 - 129% for carpal tunnel releases, 33 -100% for rotator cuff repairs and 27 - 78% for arthroscopic procedures generally. The authors concluded that financial incentives connected with equity influenced clinical practice⁸.
- 3.5 This finding has been repeated many times. In June 2012, the Workers Compensation Research Unit in the USA looked at the effect of doctors owning surgery centres and the growth in their numbers in the USA. They studied 941 surgeons in Florida and concluded that doctors owning surgery units performed 52 - 110% more treatments than those who did not and that doctors who became owners of such units increased the numbers of operations by 14 - 22%.⁹
- 3.6 These findings were repeated in a study in Health Affairs which concluded: *“Many physicians confronting declining reimbursement from insurers have invested in ambulatory surgery centres, where they perform outpatient surgical and diagnostic procedures. An ownership stake entitles physicians to a share of the facility's profits from self-referrals. This arrangement can create a potential conflict of interest between physicians' financial incentives and patients' clinical needs. Our analysis of Florida data for five common procedures revealed a significant association between physician-ownership and higher surgical volume”*.¹⁰
- 3.7 We would also highlight that this issue may also have a wider public interest affecting the NHS. The British Medical Journal published 14 March 2013 reported that more than one third of doctors on GP commissioning groups had directorships or shares in private companies which would be providing treatment.¹¹
- 3.8 Any ban will need sufficient enforcement in order to be effective. We consider that such a ban ideally needs to have the force of law, for example as operates in the United States. The US authorities have a considerable experience of regulating fee for service medicine. The US government has enacted a series of statutes namely the Stark Statutes which deal with the issue of equity and The Federal Anti-Kickback statute (a criminal statute that prohibits the exchange (or offer to exchange) of anything of value, in an effort to induce (or reward) the referral of federal health care programme business. These laws are designed to protect its Medicare and Medicaid health funds from the effects of incentives and doctors' equity.
- 3.9 Any prohibition should ideally cover both the payment and receipt of incentives.
- 3.10 In addition we would point out that there is further action which can and should be taken. The current position is characterised by the following features:

⁸ Effect of Physician Ownership of Specialty Hospitals and Ambulatory Surgery Centres on Frequency and Use of Outpatient Orthopaedic Surgery Arch Surg 2010;145 (8) : 732-738

⁹ Physician-owned surgery centers come under researchers' scrutiny <http://www.riskandinsurance.com/story.jsp?storyId=533348862> accessed 10 September 2013

¹⁰ Physician-ownership of ambulatory surgery centers linked to higher volume of surgeries. [Health Aff \(Millwood\)](#). 2010 Apr;29(4):683-9

¹¹ BMJ investigation finds GP conflicts of interest “rife” on commissioning boards: BMJ 2013 346:f1569

- 1 the widespread use of incentives to promote tests and treatments of particular types;
 - 2 the existence of excessively high profit margins in exactly those areas most amenable to influence through incentives; and
 - 3 these super profit margins tend in our experience to be highest amongst those providers with strong market power.
- 3.11 Whilst a ban on incentives would be a significant step in the right direction we remain concerned that:
- 1 any ban may be partial or imperfect, and capable of circumvention by an inventive hospital operator;
 - 2 the motivation provided by excessive profit margins in specific areas will still exist; and
 - 3 these excessive profits in and of themselves represent a significant consumer detriment.
- 3.12 In an ideal world, the ability to procure on an efficient basis on the part of hospitals would be both incentivised and have a positive impact on consumers. We are concerned that this is not the case at present.
- 3.13 To overcome these issues we propose an additional remedy. For a prescribed list of tests, scans and drugs, to be defined, insurers should have the right to make their own procurement arrangements from wholesalers of these products and services. Hospitals and clinics would then be required either to charge at the same rate as that secured by the insurer or to make use of the separate wholesale arrangement made by the insurer. We believe this would very significantly increase the level of price competition for these services to the benefit of the consumer.
- 3.14 We are further concerned that there is great disparity in the hospital charging for a significant number of procedures (more than 100) which are more commonly treated as outpatient procedures within the NHS, but for which we are charged routinely as more expensive Daycase procedures by private hospitals. We accept that there may be a proportion of such cases which do require to be carried out on a Daycase basis but we expect this proportion to be far lower than we currently experience. We believe this is another key area of customer detriment. We believe a remedy in this area could have significant and rapid effect to reduce cost for consumers. We are currently considering this topic further and will revert on this matter.
- 3.15 In response to each of the questions asked by the Commission:
- (a) Is the remedy practicable? What framework of rules could be used to determine reasonably and practically whether the benefits of an incentive scheme in terms of lowering barriers to entry, outweighed the distortions created? What degree of oversight would be required to monitor compliance and who should fund it and exercise monitoring? How could the 'fair market price' test be monitored and enforced and who would be responsible for doing so?***

- 3.16 We believe this remedy is practical and should be implemented in respect to a ban on incentives: the exercise of professional judgment should be, and be seen to be, free of financial interest in the outcome. We do not believe in allowing incentives to lower barriers to entry. We consider this latter proposal would cause confusion as to which incentives were allowed. They would also raise the issue of how long should an incentive be allowed to continue once market entry is obtained. Finally existing providers will not be competing on a level playing field unless they too are allowed to incentivise consultants. In our view patients see a doctor expecting to receive an objective opinion and as far as possible the decision to refer a patient for treatment should be kept separate from the financial benefits from the provision of the treatment.
- 3.17 We have set out below areas based on our own experience and that from the US where distortions are particularly likely to occur.
- 3.18 We believe that in parallel to the remedies proposed we consider there is a need for a comprehensive register of the interests of doctors. This should record all arrangements and should set out the specifics and the value of each arrangement. Such a register should not be confined to private healthcare arrangements but include those which may impact on public services. It would, for example, include not only declarations such as provision of a consulting room and the value of the rental paid, but also any payments or benefits in kind that doctors receive from device manufacturers or pharmaceutical companies.
- 3.19 The enforcement of such a register and the CC provisions would be strengthened if the professional regulators – the General Medical Council, The Nursing and Midwifery Council and the Health Professionals Council and the Care Quality Commission who regulate hospitals could be persuaded to incorporate this into their regulatory remit and that there should be enforcement processes including fines/sanctions.
- 3.20 Failing this it might be necessary to create a new regulator.

The fair market test for rental property should be achieved by obtaining an independent valuation.

(b) Is the remedy reasonable? Should certain kinds of arrangement still be permitted and if so which? Should, for example, those with a value of less than a certain amount, be deemed 'de minimis'? If so, what should this figure be?

- 3.21 As stated above, there is strong evidence of harm from such arrangements and they appear to be designed to influence behaviour. We believe that the average member of the public expects and believes that the services they obtain from a doctor are given on an objective basis and they would be very concerned if they understood the scale of incentives being offered and the implications of these on the exercise of professional medical judgement.
- 3.22 The issue of GP incentives seems to us to be a particularly clear cut example where there should be prohibition. The role of the GP is to provide medical care in the primary care setting and to refer the patient on where secondary care is required. There seems to us to be no justification for a GP to enter into arrangements designed to incentivise referrals into secondary care as this may have two consequences:

- Firstly to incentivise unnecessary referrals i.e. referrals for care that could be carried out in the primary care setting
 - Secondly to influence the place where treatment is provided.
- 3.23 We believe that GPs should be prohibited from having any financial interest or link with organisations into which they refer patients.
- 3.24 The Commission has asked whether we believe that certain types of arrangements should be permitted. We believe the much preferred position is that no incentive arrangements are allowed. However should the CC not agree we have suggested below remedies that may mitigate some of the problems.
- 3.25 Firstly we would like to comment that the potential for services to be influenced is greatest where:
- Investigations or treatment involve a high degree of judgement or discretion;
 - The service provided is one which is non-invasive and low risk;
 - Wide variations in practice exist.
- 3.26 Services we believe to be particularly prone to influence are those set out specifically in the Stark laws in the USA. Although the Stark Statute relates to equity, as stated above we believe that doctors' equity in clinics and institutions providing care has the effect of, and is similar to, the provision of financial incentives.
- 3.27 Services set out in the current version of the Stark Statute where doctors may not refer patients if they or their family have any financial interest are called designated healthcare services and are as follows:
- (1) Clinical laboratory services;
 - (2) Physical therapy, occupational therapy, and outpatient speech-language pathology services;
 - (3) Radiology and certain other imaging services, except for the following, which are not considered to be DHS:
 - (a) X-ray, fluoroscopy, or ultrasound procedures that require the insertion of a needle, catheter, tube, or probe through the skin or into a body orifice;
 - (b) Radiology or certain other imaging services that are integral to the performance of a medical procedure that is not identified on the list of CPT/HCPCS codes as a radiology or certain other imaging service and is performed:
 - (i) immediately prior to or during the medical procedure; or
 - (ii) immediately following the medical procedure when necessary to confirm placement
 - (4) Radiation therapy services and supplies;
 - (5) Durable medical equipment and supplies; (not applicable in the UK)
 - (6) Parenteral and enteral nutrients, equipment, and supplies; (not generally applicable)

- (7) Prosthetics, orthotics, and prosthetic devices and supplies;
- (8) Home health services;
- (9) Outpatient prescription drugs; (not applicable in PMI)
- (10) Inpatient and outpatient hospital services.

We comment on these below.

- 3.28 *Clinical laboratory services* are very vulnerable to abuse. Once a vial of blood is drawn, there is virtually no limit to the number of tests that can be conducted, nor the number of times a vial can be tested. There are a whole range of abuses in private laboratory services (repeated unnecessary analysis, unbundling, tests of no real value, manipulation of order forms and analyser configuration) to maximise revenue. There are super profits being made – tests costing £2.50 may be billed at up to £200. A recent article in the British Medical Journal stated that it costs 12p to add a test to a profile and our own experience shows additional charges of £40 - £50 can be made in the private sector.¹² It is important to break the link between the ordering of tests and the direct benefit to those ordering them
- 3.29 *Physiotherapy Occupational Therapy etc.* These are services which are prone to abuse mainly in the form of overtreatment. They are of low harm. Doctors should be prohibited from having any financial involvement in provision of these services for which they are the gatekeeper.
- 3.30 *Radiology.* As with Clinical laboratory services, these tests have no immediate harm and are non-invasive. They are prone to overuse and there is strong evidence of financial considerations affecting the rate of tests ordered. A study in the American Journal of Roentgenology¹³ showed that doctors with financial interests were 1.87 times as likely to order tests. More interestingly behaviour was noted to change with a 49% increase in the number of tests ordered when a financial interest was acquired. Doctors making referrals for imaging should not be allowed to have a financial interest in its provision except where the imaging is part and parcel of a medical procedure as set out in the Stark law.
- 3.31 *Radiotherapy.* This is an area where there are variations in treatment. This is prone to being influenced in two ways. Firstly there are a number of new modalities – such as Intensity Modulated radiotherapy, Cyberknife, and Proton Beam therapy. These tend to cost significantly more than conventional treatment, perhaps three times more. There are relatively few indications where there is strong evidence of incremental benefit but they can be used as a perfectly acceptable alternative in many normal tumours. These are the source of great conflict between insurers and consultants as the latter try to extend the use of these technologies well beyond the areas for which there is evidence of benefit. For this reason we believe that doctors referring for radiotherapy

¹² Time to harmonise common laboratory test profiles: BMJ 2012;344:e1169

¹³ Clarifying the Relationship Between Nonradiologists' Financial Interest in Imaging and Their Utilization of Imaging: <http://www.ajronline.org/doi/abs/10.2214/AJR.11.7019> : accessed 10 September 2013

should not be allowed to have any financial interest in its delivery. The second potential source of harm from financial interests is where excess fractions of radiotherapy are delivered for financial reasons.

- 3.32 *Prosthetics and orthotics.* It has been the practice of a number of doctors to supply prosthetic and orthotic devices. Doctors are often subject to influence from equipment manufacturers and new devices are constantly introduced without proper assessment of cost/benefit. In the USA, a register of interests is maintained and these are disclosed on the manufacturer's sites. The link below is to a register of all doctors receiving more than \$5,000 per annum from Medtronic¹⁴. Some of these payments are as much as \$200,000 per annum (\$50,000 per quarter). We believe that doctors should be forbidden to have any financial interest in prosthetic devices they supply, whether this is by virtue of their bypassing hospitals and supplying items to patients directly or by their receiving incentive or consultancy payments from equipment suppliers. We understand a voluntary register of such payments is being considered. We believe this does not go far enough and that doctors should not be allowed to supply prostheses.
- 3.33 *Home health services.* A number of parties have submitted evidence that certain home health services are paying incentives to doctors to use their services. The above proposed remedy would stop all such payments and we believe this is appropriate.
- 3.34 The final category appears to be a catch-all.
- 3.35 To the above list of services, AXA PPP believes that cardiac testing should be added. We have provided case studies and a reference from the literature as to the harm arising from medical ownership of cardiac testing with the JAMA study referred to further above, showing that the odds ratio of some tests being ordered can be influenced by a factor of up to 12.8 times.
- 3.36 We have given consideration as to whether there are agreement models that could be enacted with specialists so that the consequences of incentives can be avoided. We are not confident that any such solution will not in itself be gamed or have unintended consequences. An example to consider is that specialists are prohibited from charging anything other than cost price for any service provided by a third party, e.g. a pathology laboratory. In addition, that specialists must use a third party provider determined by whoever is paying for the service e.g. the insurer.
- 3.37 However it remains our view that the ideal situation is that doctors provide consultation and treatment and that all services to which they refer are chosen at arm's length i.e. there is a total prohibition on any financial interests whatsoever.

(c) Is the remedy comprehensive? Should it apply to other healthcare service providers such as laboratories or firms supplying diagnostic services such as imaging, for example? Should PMIs be permitted to

¹⁴ <http://www.medtronic.com/about-us/corporate-social-responsibility/physician-collaboration/physician-registry/index.htm> : accessed 10 September 2013

operate incentive schemes which reward consultants who recommend cheaper treatments or less expensive hospitals?

- 3.38 This remedy should apply to all healthcare service providers including laboratory services. We have previously submitted evidence that a private laboratory service was paying significant kickbacks in return for pathology tests. We also have concerns about payments to doctors by manufacturers of drugs and medical equipment.
- 3.39 PMIs should not be able to operate incentive schemes to reward consultants who recommend cheaper treatments or less expensive hospitals. This might introduce damaging changes in behaviour. However PMIs should be free to offer directed referral products which seek to maximise value for money provided this directional referral is made clear to customers in the literature and customers are able to purchase alternative products should they wish.

(d) Are there regulatory regimes in other jurisdictions that the CC could learn from in the context of remedy specification and implementation? Would, for example, the Stark Law in the USA, be a useful model as regards restrictions on the introduction?

- 3.40 The Stark Law as amended does form a good basis as discussed above. However by setting out too precisely what cannot be done, it also sets out where incentives can be applied.
- 3.41 It needs to be understood that the Stark Law is about equity. The USA also has regulation known as the Federal anti-kickback statute, also known as The Medicare and Medicaid Patient Protection Act of 1987 (42 U.S.C. 1320a-7b) .
- 3.42 The Medicare and Medicaid Patient Protection Act of 1987, as amended, 42 U.S.C. §1320a-7b (the "Antikickback Statute"), provides for criminal penalties for certain acts impacting Medicare and state health care (e.g., Medicaid) reimbursable services. Enforcement actions have resulted in principals being liable for the acts of their agents. Of primary interest is the section of the statute which prohibits the offer or receipt of certain remuneration in return for referrals for or recommending purchase of supplies and services reimbursable under government health care programmes.
- 3.43 It also needs to be understood that the USA has a strong regulatory regime policing the healthcare laws and their enforcement is high on the priority list of enforcement agencies including the Federal Bureau of Investigation. There is a strong public/private partnership in the USA in the form of the National Healthcare Anti-Fraud Association (<http://www.nhcaa.org/about-us/who-we-are.aspx>) where the two sectors work together.
- 3.44 This robust enforcement framework does not currently exist in the UK. A current difficulty with the UK medical system is that regulation by the GMC and CQC is not effective. Paragraph 8.111 of the CC's provisional findings document highlights the limitations of the GMC as a regulator. Consultation needs to take place with the regulators to ensure that their remit is extended to effective enforcement of such legislation or alternatively an alternative policing scheme needs to be implemented.

(e) What would be the cost of implementing this remedy, particularly in terms of unwinding existing equity sharing arrangements? Would it be necessary or desirable to ‘grandfather’ existing arrangements?

- 3.45 The Commission has set out in its submission evidence of the widespread nature of these arrangements and in London in particular. We believe that grandfathering such arrangements would actually be counter-productive as the adverse effects would remain but new entrants would be unable to compete with them. We believe that a short timescale needs to be given for these to be unwound so that they can be done without undue further cost.

(f) Particularly in the context of market entry and expansion, are any relevant customer benefits likely to arise from equity participation by consultants in hospitals that would not otherwise be available?

- 3.46 It is our view that new entrants and new technologies should compete on their merits. Providers of a new hospital or new treatment should be perfectly entitled to consult with doctors about a new build or treatment facility they may intend to build. This would include getting their views as to the value and usefulness of any technology. Providers should not have risk removed by having agreements in place to transfer work and or use a new technology based on inducements. We are firmly of the view that incentive schemes are anti-competitive and anti-consumer.

- 3.47 We note that the CC may be minded to take the view that there can be benefits to the use of incentives in some circumstances. With specific reference to the examples that we are aware of, we would make the following observations:

(a) We accept that the use of equity incentives by Circle in Bath may well have assisted in market entry. However, this was in the context of the use of incentives by the incumbent BMI hospital. We would contend that since a new entry was achieved where there was a level playing field of incentives, clearly it would also have been achieved in the complete absence of incentives. As the latter state is a better outcome for consumers, we do not recognise the argument for incentives in this instance.

(b) We are aware that operators seeking to introduce a new piece of equipment (eg a Cyberknife or similar) need to secure the commitment of consultants (eg oncologists). Whilst we are clear that such operators have a perfect right to market to such oncologists the efficacy of their equipment, we see no need to allow an exception regarding incentives. We remain of the view that consumers pay fees to consultants in return for professional and objective advice on their own particular case. In relation to new equipment, having explained the use and efficacy of a particular new piece of equipment to local consultants, if those consultants prefer not to recommend use of that equipment, we would tend to the view that this reflects a lack of credibility for the new equipment. To suggest that incentives are justified to change this outcome can only be based on the proposition that the original advice these consultants are providing is incorrect, and we have seen no evidence to support this view. Additionally, it is known that incentives do distort referral patterns (indeed that is their purpose), and it is not clear that where there is an alleged failure to provide proper medical advice that the solution is to allow an additional failure in medical ethics to resolve the initial problem.

(c) We are particularly concerned that the allowance of an exception for new facilities will allow operators to game the system to avoid the more general prohibition. For example, operators can seek to introduce any number of minor, novel services, which would then be used as an excuse for providing incentives whose actual purpose is to avoid the broader prohibition.

(d) It does not appear clear to us when a new entrant would no longer be classified as such. We assume that there would be some form of time limit, as clearly any measure relating to profitability would be problematic. Similarly, there would need to be clarity as to the level of incentive that would be allowed – how could a regulator determine the difference between an allegedly reasonable “pump prime” incentive and one whose effect will be to distort the market unduly, and how could such an assessment be made without reference to objective evidence as to the efficacy of the new treatment?

3.48 For these reasons, we remain of the view that the ban on incentives should be without exception.

4 Lack of sufficient publicly available performance information on consultants facilities

4.1 We agree that information on consultants’ qualifications and specialisms is available through a combination of web sites. However we believe this information is of varying quality and lacks standardisation. Furthermore accessing this information requires effort and knowledge on the behalf of consumers in order to make use of this. For example some specialists may list themselves as an orthopaedic surgeon, another as an orthopaedic surgeon with a special interest in a particular field and another may give a much longer list of special interests. We consider there would be a consumer gain by collating this information together in one place with greater standardisation and quantification. By way of example, if a specialist has a special interest it would be useful to know how this is demonstrated through qualifications, membership of associations, publication of research papers, the number of patients with the conditions seen and number of procedures in this field undertaken in recent past.

4.2 We agree with the CC that consumer information on consultant fees is an area for improvement. We consider that specialists should make patients aware of their charges before patients have incurred any costs. Levels of charges for outpatient consultations are not sufficient and specialists should include costs of all, or certainly the most common, procedures they perform. We consider that the position of specialist services such as anaesthetic charges present a particular problem as we have highlighted to the CC previously. We will not run through these arguments in detail but essentially these are not services where consumers can exercise choice, particularly at the start of their treatment journey. It is our view that such services should be billed through the hospital or the surgeon as the CC suggested earlier. However in the absence of this we consider there is consumer benefit in requiring that surgeons quote the level of any anaesthetic fees charged alongside their own fees. These fees must represent the “all inclusive” price setting out the total cost rather than line items. Furthermore these fee levels should represent the maximum charge and patients must not be charged in excess of these.

4.3 The provision of meaningful outcome performance measurement is considerably more problematic. Without a measure of quality there is a danger that price is used as a proxy producing an increase in costs rather than the market acting to keep costs down for the consumer. The recent initiatives in NHS England in publishing outcome data are interesting but also illustrate the difficulties and limitations of trying to measure quality based on clinical outcomes. Essentially the initiative may give information which identifies a small number of specialists whose outcomes appear unsatisfactory or at least those which need further scrutiny. This is quite some way from a meaningful data set which allows more subtle distinction between marginal cost increase and marginal improvement in quality.

4.4 ***Remedy 5 - a recommendation to the health departments of the nations***

We would make a recommendation to the health departments or their equivalent bodies in Scotland, Wales and Northern Ireland that they collect and publish on their most appropriate patient-facing website individual consultant performance indicators to include activity and clinical quality measures across the same or an equivalent range of medical specialties to that included in the NHS England scheme. Data would, as in England, be standardized so as to permit a genuine like-for-like comparison between consultants in the same specialty but working in different parts of the UK.

(a) Is the proposed remedy practicable in all of the nations? Where a consultant practises partly in one nation and partly in another should performance data published in one nation be confined to that relating to performance in that nation?

We believe that the proposals are practicable. We consider that for the reporting of performance, this would include data amalgamated from the consultant's practice across national boundaries

(b) Is the proposed list of ten specialties for which performance data will be available on an individual clinician basis appropriate?

4.5 We believe this is an appropriate starting position. We consider that should the initiative prove its value, it should be rolled out to a larger list of specialties with different measures included.

(c) Are the indicators that are currently published for consultants in each of the ten specialties, the way they are presented and the manner of their distribution appropriate? Are they (or some combination thereof) appropriate for other areas of specialty? If not, which indicators would it be appropriate to adopt for each specialty and how should they be presented and distributed?

4.6 We consider it is too early to reach a conclusion on this matter.

(d) Does the remedy risk giving rise to unintended consequences? Even with standardized mortality rates, might consultant incentives to treat more seriously ill patients be affected?

- 4.7 There is a potential for unintended consequences. The data is aimed at identifying extremes of results for further investigation. The data does not produce a simple league table of quality. Given the limitations of methodology, specialists will also be identified as performing badly due to chance. Another unintended consequence is that surgeons will avoid difficult cases to improve their score. However if the methodology developed adjusts correctly for case mix this should not be a problem. A further unintended consequence might be that the initiative incurs substantial costs and has no impact on the choices made by consumers.

(e) With what frequency should performance indicators be updated?

- 4.8 We consider an annual update would be reasonable.

Remedy 6 - An information remedy: Consultant fees

We would require all consultants practising in the private healthcare sector to publish their initial consultation fees on their websites and we would require each private hospital where they have practising rights to publish these fees on their websites. We would, further, require consultants to provide a list of proposed charges to patients in writing, in advance of any treatment.

(a) Is the remedy practicable? Do consultants' outpatient fees vary significantly between different patients such as to render an average fee or a range of fees unhelpful?

- 4.9 We believe the remedy both practicable and helpful.

(b) Is it possible for consultants to estimate fees before undertaking a procedure since unforeseen complications may arise? Would there need to be a means of adjusting fees in response to complications? Are there particular medical specialties where consultants would face particular problems in providing such an estimate in advance? How else might patients be informed of the likely costs of their treatment?

- 4.10 We consider it is reasonable for consultants to make clear their fees. We believe these should not be an estimate but rather a “quote” which is an all-inclusive fee. We consider that this inclusive fee level should include coverage for complications. With regard to non -surgical specialities such as general medicine it is much more difficult to predict what treatment will be needed and for how long. However we believe there is room for improvement here and that specialists should state a rate per day which is all inclusive.
- 4.11 We further recommend that, in light of the CC's provisional finding in respect of anaesthetist groups, hospital groups should provide price estimates which cover of all professional fees except the surgeon, on the basis that consumers rarely have real choice for those other services.

(c) Is it reasonable to require all consultants practising in the private sector to disclose their outpatient consultation fees? Should only those earning above a certain level do so?

- 4.12 It is reasonable for all consultants to disclose their fees. Outpatient consultation fee publication is insufficient.

(d) How should the remedy be specified? How far in advance of treatment should a consultant be required to provide a patient with an estimate of the proposed fees for treatment? Is it practical, in all cases, to inform patients of costs in advance of treatment? Should any other information or advice be included with the estimate? For example, should the consultant notify the patient of his or her PMI fee maximum for the procedure concerned, or advise the patient to check this him or herself?

- 4.13 We consider that all prospective patients should be aware of the level of fees charged by a specialist. We consider that these fees should cover the whole range of services a specialist might perform as discussed above. Indeed we consider that these fees should include other specialist fees that might reasonably be expected, most notably those of anaesthetists. We also consider that once a consultant agrees to see a patient this fee level cannot be changed without adequate notice. We suggest this notice period be one year.

(e) What provisions would need to be made for the oversight and enforcement of this remedy and which body(s) should be responsible?

- 4.14 We consider there will need to be effective enforcement of these proposals. We have discussed in other sections the limitations of current regulators. Current regulators either need to be given the power and duty to do this or a new regulator found.

5 Lack of sufficient publicly available information on private hospital performance

- 5.1 We agree that the level of information on private hospitals should be at least as good as that available for NHS hospitals in terms of quality assurance. In addition to the proposed recommendations we suggest that the CC recommend that all providers be required to post the latest CQC inspection report (or appropriate regulator outside of England) in prominent positions including their websites and main entrances to buildings. See **Exhibit 1: Example of CQC report summary**.
- 5.2 Regarding provision of prices for self pay we believe hospitals could be much clearer to potential customers regarding costs for self pay customers. We consider that consumers would be aided by hospitals publishing a price for the common operations provided. This price should include all aspects of the treatment including specialist fees and treatment of complications.

Remedy 7—An information remedy

The CC would require that all private acute hospitals in the UK collect HES equivalent and PROMs data for private patients and that appropriate arrangements are made for its publication to consumers.

(a) Is the remedy practicable? Are all private hospitals in the UK capable of collecting the equivalent of HES data? If they are not currently capable of doing so, what would be a reasonable timescale for the implementation of this remedy?

5.3 We consider it practicable and believe a two year timescale reasonable.

(b) Similarly, are all private hospitals in the UK capable of collecting PROMs data for the same procedures that it is collected for NHS England? If they are not currently capable of doing so, what would be a reasonable timescale for the implementation of this remedy?

5.4 We believe that private hospitals should be able to do this and if not a two year time scale would be reasonable.

(c) Besides HES and PROMs equivalent data, what other data should be collected by private hospitals and to whom should it be made available? Would it be appropriate for the CC to specify the coding, for example ICD10, to be used in data collection and classification?

5.5 We consider it is preferable to focus on the above data issues rather than expanding it to include other information such as ICD10 coding.

(d) What measures could or should the CC adopt in order to ensure that PHIN or its equivalent retains sufficient funding to continue its activities after the completion of the CC investigation?

5.6 We consider the CC should recommend that all hospitals and specialists participate in collection of this data. We further suggest to the CC that publication is mandated and forms part of regulator's inspection regime. Funding should come from hospitals, the allocation of which for them to determine.

(e) What cost and other factors should the CC take into account in considering the reasonableness and proportionality of this remedy or the timing of its implementation?

5.7 We consider it is reasonable for the CC to make a judgement around the above issues taking into account responses from providers. The CC will need to assess if the cost is justified in terms of making a difference to consumers' choice between providers.

6 Remedies we are minded not to consider further

Remedy 8 - A price control

6.1 We concur with the CC's view that a price control would be complex to design and update, would require adjudication in the event of disputes and would be likely to have unintended consequences. In general terms, price control is rightly almost never regarded as being as effective, as efficient or as clean a remedy as divestment to cure an underlying structural problem of market power, and the fundamental difficulties of implementing price regulation for medical

procedures imply that this general presumption applies with even greater force in this specific market.

- 6.2 As noted in section 1 to deal with the problem of excessive charges for medical tests once the patient/insurer has chosen the hospital, we have suggested above a procurement remedy which should assist price competition as regards a material element of costs relating to hospital treatment and which avoids the drawbacks of price control.

Exhibit 1: Example of CQC report summary



We are the regulator: Our job is to check whether hospitals, care homes and care services are meeting essential standards.

Nuffield Health Tunbridge Wells Hospital

Kingswood Road, Tunbridge Wells, TN2 4UL

Tel: 01892531111

Date of Inspection: 22 January 2013

Date of Publication: February 2013

We inspected the following standards as part of a routine inspection. This is what we found:

Respecting and involving people who use services	✓ Met this standard
Care and welfare of people who use services	✓ Met this standard
Safeguarding people who use services from abuse	✓ Met this standard
Supporting workers	✓ Met this standard
Assessing and monitoring the quality of service provision	✓ Met this standard