

Response of



to

Private Healthcare Market Investigation
Remedies Notice – Remedies 2 to 8

11 November 2013

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REMEDY 1

REQUIRE BMI AND SPIRE TO DIVEST ONE OR MORE HOSPITALS (THE DIVESTITURE PACKAGE) IN THOSE LOCAL AREAS WITH CLUSTERS TO A SUITABLE PURCHASER

1. **Remedy 1**
- 1.1 Due to the inclusion of confidential information from the CC's local competitive assessments and in accordance with the confidentiality ring undertakings, BMI's response to Remedy 1 has been submitted separately. Any references to paragraphs 1 – 17 in the response below is to be construed as referring to BMI's response to Remedy 1.

REMEDY 2

PREVENTING TYING OR BUNDLING

18. **Applying Remedy 2 only to HCA, BMI and Spire is ineffective, punitive, discriminatory and unlawful**
- 18.1 The CC's provisional decision that BMI, Spire and HCA have market power and that Nuffield, Ramsay and Circle do not, is derived from the CC's profitability analysis. This is a global analysis. It does not (and does not seek to) adapt to the position in markets that the CC has accepted are local. In a given market the local BMI hospital may be the stronger of the available competitors but it may also be the weaker competitor. In either case the BMI hospital will be the one subject to the remedy whereas a competitor facility owned by Ramsay, Nuffield, Circle, Aspen or anyone else would not. This will lead directly to perverse outcomes.
- 18.2 In Oxford, for example, Nuffield has a strong hospital (Nuffield Manor). BMI entered and attempted to compete against Nuffield via the BMI Oxford Clinic. This entry attempt was unsuccessful and BMI exited the business with a sale to Nuffield in 2012. There is no rational or lawful basis to hamper BMI, Spire and HCA's ability to enter and compete in these circumstances. In particular BMI is concerned that a hospital operator not subject to the remedies would be allowed to set national volume discounts and more effectively cross-subsidise hospitals in their portfolio. This greatly increases the prospect that – in a given local market - the BMI hospital would be the hospital that would be forced from (or successfully deterred from entry to) the market – regardless of its competitive merits.
- 18.3 The private healthcare market is characterised by a large number of competing suppliers. It is not the CC's case that one or more players have an intrinsic advantage deriving from a natural monopoly or essential technology etc. that requires a remedy to 'level the playing field'. However, whatever the correct view of the case against BMI, it is clear that behavioural pricing remedies that apply to it and to Spire alone (as outside London that would effectively be the reality) would make highly undesirable distortions to competition inevitable – especially over time.
- 18.4 The remedy would force BMI, Spire and HCA into relative decline as competitive forces. Others may then take their place.¹ This is not merely a justification for some type of review mechanic or sunset provision, although that undoubtedly would also be necessary. First, it is already the case that in some local markets BMI is the weaker competitor. Second, there is no prospect whatsoever that the regulatory regime under a remedy either could

¹ As noted in BMI's response to Remedy 1, the CC's intervention will of itself substantially discourage investment in the sector. Investors will be understandably anxious that their investments could suffer the same fate that BMI, Spire and HCA have been subject to, especially as they would face a dominant firm customer (Bupa) [3<].

(or is designed to) respond sufficiently quickly to changes in competition in local markets that would make the remedy otiose or counterproductive. BMI notes that the OFT gives over several paragraphs of its submission on remedies to this problem of 'future proofing'.

18.5 Maintaining the behavioural remedies against BMI, HCA and Spire alone therefore would be ineffective, punitive, discriminatory and unlawful. Ramsay submit that there is no legal basis to extend the remedy to cover them.² This is wrong. To the extent that an AEC can be adequately demonstrated, the CC is empowered to take such action as is reasonable and practicable to remedy that AEC or its adverse effects. If the CC wishes to impose behavioural regulation on the sector, that regulation can and must apply across the whole sector.

19. Remedy 2 could only apply to private insured inpatient fees

19.1 The CC has focused its investigation on private insured inpatient work. Even on its own case, it only has evidence of features causing adverse effects in respect of private inpatient across a limited number of workstreams, as follows:

- (a) The CC's barriers to entry analysis only finds barriers in respect of "full service" (i.e. inpatient hospitals);
- (b) The CC's price concentration analysis does not apply to private insured work at all, as it is derived from self-pay. Even if the CC is able to claim it can use the self-pay PCA to imply findings about private insured (which it cannot), the analysis has only looked at four inpatient episodes. The PCA captures a fraction of BMI's work. No rational authority can reasonably extrapolate a broader conclusion from such a narrow base – especially when even the basis for such extrapolation is so weak.
- (c) The CC has, in conducting its local assessments, always discounted as ineffective any constraint from facilities that do not offer inpatient services;

19.2 In respect of the PCA, even if the conclusions were robust (which they are not) the CC could not simply "port across" the price concentration relationship seen in self-pay to insured work.³ For instance, the CAT said in *Barclays* that the CC did not need to consider each distributor separately as it had collected evidence from a substantial number of distributors and:

² Ramsay Response to Remedies Notices, paragraph 4.5 et seq.

³ Provisional Findings paragraph 6.290.

“in all that evidence, no observable differences between individual distributors’ markets which called for a separate market by market analysis of each”⁴

19.3 The CC does in this case have access to very significant evidence suggesting observable differences between the self-pay and PMI markets drawn, from the CC’s survey, the parties’ internal documents, the pricing and marketing of these separate products etc.

19.4 There is no evidential basis therefore for the remedy to apply to daycase, walk-in-walk-out or outpatient procedures. BMI notes that a remedy must not be any more onerous than is necessary to achieve its legitimate aim.⁵

20. Remedy (2a) – the CC's proposal

“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.”

20.1 BMI has considered what the CC's proposal might mean and what it might be trying to achieve. There are a number of questions regarding interpretation, contingencies and potential consequences of this remedy. This response is structured by reference to these questions. Although the discussion of these questions overlaps with many of the CC’s consultation questions in the Remedies Notice, it is important that the debate is not constrained by these questions which are themselves poorly suited to exploring many of the key issues. That said, for the CC’s convenience, a table cross-referencing the points relevant to its consultation questions is provided at the end of this section. That table does not replace or obviate the need to read the discussion below.

21. Does the CC intend to prohibit contractual provisions that prevent BMI from altering national price as a result of a change in local network policy?

21.1 If the CC’s provisional finding that BMI has market power opposite PMIs were true, we might expect to observe [X], or similar, in wide use. The CC's theory of harm requires BMI to have the upper hand in negotiations with PMIs. If so, BMI would be able to determine PMI networks so as to favour itself [X].

21.2 [X].

21.3 [X].

⁴ *Barclays v Competition Commission* [2009] CAT 27 paragraph 62.

⁵ Guidelines for market investigations, (CC3, Revised), paragraph 344.

22. Does the CC intend to prohibit contractual provisions that prevent BMI from altering local price as a result of a change in local network policy?

22.1 Some insurers opt to procure private healthcare services on the basis of exclusive or tight networks.

22.2 The PMI explicitly designs the network to support a PMI product that is lower cost but offers a more limited choice of hospitals. The insurer then asks private healthcare providers for lower prices on the basis that a limited number of competing hospitals will be included in the network – hence the private healthcare provider can expect more of the volume generated by the network policy. This provides the economic rationale supporting the deeper discount. Any procurement conducted on this basis is likely to have a restriction on being able to add other hospitals to the network, this being at the heart of the commercial bargain offered by the insurer in order to attract keener pricing. AXA PPP is the main proponent of this strategy.

22.3 The standard acute AXA PPP network contract [REDACTED].

[REDACTED]

22.4 The AXA PPP Pathways agreement [REDACTED]:

[REDACTED]

22.5 [REDACTED]

22.6 BMI has [REDACTED] raise prices as a consequence of network policy change. Circle Bath's recognition by AXA PPP is the prominent example, where there was no change in BMI pricing as a result of recognition of Circle Bath. As AXA PPP explains: "*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.*"⁶ [REDACTED]

22.7 Both BMI and AXA PPP have made this point repeatedly to the CC. It is odd that the CC has chosen to ignore this evidence to date. Both sides of the bargain – whose interests are not aligned in the inquiry - have independently provided a consistent interpretation of an event that is highly relevant to the CC's theory of harm. This would usually be considered as both relevant and compelling evidence.

22.8 The fact that BMI has not [REDACTED] raise prices is also implicit even in AXA PPP's (now adjusted) statement that BMI has not used any market power it might have (PFs, Appendix 6(11) paragraph 12(b)).⁷

⁶ AXA PPP Response to PFs, paragraph 2.68.

⁷ [REDACTED]

22.9 The fact that [X] demonstrates that a prohibition on this provision is highly likely to be ineffective. [X] It would also self-evidently be more onerous than needed to achieve its aim and hence disproportionate.

23. Does the CC intend to prohibit tight/restricted or exclusive PMI networks?

23.1 The main restrictive networks are negotiated with AXA PPP. For historical reasons, AXA PPP has a regional pricing structure. Does the CC intend to ban the current AXA PPP pricing structure or even future national “tight network” price structure or both?

23.2 AXA PPP appears to have recognised the risk of this: *"Such arrangements [tight or restricted networks] may be materially or even fatally undermined by the imposition of a ban on tying/bundling."*⁸

23.3 Not having an incentive [X] is one thing,⁹ being prohibited *ab initio* from raising price in response to a network change is clearly another. In the context of restricted networks, it would remove any incentive for BMI to operate such arrangements and remove from PMIs a commercial choice that some of them, such as AXA PPP, have legitimately chosen.

23.4 If this is the intention of the remedy, BMI would have expected the remedy to be more simply stated. It would also expect an analysis of the competitive effect of exclusive or tight networks. The CC will recall that BMI has repeatedly suggested the CC conduct such an analysis – using the familiar and well established framework for understanding foreclosure effects in vertical agreements - since at least its response to the Issues Statement in summer 2012. The CC has chosen not to do this. Indeed the CC has undertaken no analysis, and offers no evidence, of any foreclosure effects of restricted networks - still less that such foreclosure effects are of sufficient importance to make intervention against them either effective or proportionate.

23.5 If it is to apply any remedy that undermines exclusive or tight network agreements, the CC will need to analyse: (i) the anti-competitive effects (if any) of the exclusive or limited agreement; and (ii) the efficiencies that result from such arrangements. Without this work, the CC has no rational basis to consider whether the adverse effect of the remedy is disproportionate to its aim.¹⁰

23.6 BMI further notes that the CC is under an obligation to quantify the effect of the CC's intervention when it is practicable and reasonable to do so. The CC's guidance anticipates that the CC will invest effort in quantifying the effect

⁸ AXA PPP response to PFs, page 19.

⁹ [X]

¹⁰ CC3 Guidelines for market investigations: Their role, procedures, assessment and remedies, paragraph 344 (d).

of a remedy proposal, especially where "*reliable data is available and [...] it is possible to quantify a particular effect with any degree of accuracy.*"

- 23.7 In this case, the CC has a full view of the market structure, has all the contracts that contain restrictive terms and can compare the volume effects of such agreements as well as the market share that is affected by them. The CC is in an excellent position – far better than a party that is undertaking a self-assessment of its agreements, or even a competition authority examining the agreement under the Competition Act 1998 or TFEU Article 101. This work could be readily done, yet the CC has apparently chosen not to undertake any of it.
- 23.8 The CC has no evidential basis on which it might rationally decide that banning exclusive or tight network agreements would be effective. It has also undertaken no work to understand whether such an intervention would be proportionate to its aim or whether it would produce adverse effects that are disproportionate to that aim, despite the fact that such work is both possible and would need to be carried out according to the standard in the CC's own guidance.
- 23.9 It cannot therefore be the intention or effect of Remedy 2(a) to ban or restrict exclusive or tight networks.
24. **Does the CC intend to prohibit contractual provisions that prevent BMI from altering national price as a result of a change in local network policy WHERE THAT CHANGE HAS AN EFFECT ON VOLUME treated by BMI?**
- 24.1 [X] changes in network policy can alter national price indirectly if delisting results in reduced volume.
- 24.2 The CC anticipates this by referring to a "circumvention" measure of "*structuring volume discounts in such a way as to make removing incumbent hospitals from its network or recognising a local rival unattractive*".
- 24.3 [X]
- 24.4 [X] The greater the volume that an insurer can deliver, the greater the discount that BMI can afford to offer to attract that insurer's business. The CC has accepted that BMI faces high fixed cost as a proportion of total cost. The CC has also accepted the economic rationale that higher volume attracts a lower unit price.¹¹
- 24.5 Banning a hospital operator like BMI from adjusting price to reflect reductions in volume (including where that reduction resulted from changes in network policy) would incentivise PMIs to 'overpromise' volume to achieve a discount

¹¹ PFs, paragraph 6.67.

level in the knowledge that 'under delivering' via network alternation would attract no consequences.

- 24.6 In such circumstances, the 'flipside' would be that a hospital operator would no longer have any rational basis to offer a volume discount at all. The CC cannot seek to simply allow PMIs to renege on volume promises that justified a given price. BMI must be free to recover efficiently incurred cost through pricing; otherwise the remedy would amount to unlawful confiscation.¹² An intervention that did not allow this would quite obviously create disadvantages for BMI – as well as undermine the legitimacy and predictability of the UK's competition regime – which are disproportionate to the aim pursued.
- 24.7 The OFT makes this point in its submission: "*How would it be proved that a change in a hospital's prices were linked to a change of policy of a PMI rather than other factors? Hospitals would and should of course be free to adjust their prices as they see fit, especially in response to competition.*"
- 24.8 The CC plainly cannot lawfully impose a remedy that does not allow changes in price which result from changes in volume where those changes impact cost. The remedy would therefore have to differentiate somehow between "acceptable" changes in price as a result of changes in volume and "unacceptable" changes in price caused by changes in volume derived from changes in network policy.
- 24.9 BMI suspects that the intuition driving this proposal is that if costs are predominately local, a delisting (or the adding of a competitor facility) in (say) Guildford should not affect the price in (say) Glasgow. [X]. BMI can see the intuitive appeal of this approach but it is badly misconceived.
- 24.10 Loss of volume from a delisting (or listing a new competitor) affects BMI's costs in two ways: (i) locally at the affected hospital(s); and (ii) central/regional costs spread over the remainder of the chain. A relevant question therefore is the extent to which delisting a hospital in (say) Guildford has on costs in (say) Glasgow. [X].
- 24.11 In terms of central costs: BMI is a chain business. Like all chains, it has a large amount of cost that is incurred centrally in order to support and increase efficiency at the local hospitals. These costs are not efficiently incurred by each hospital individually. [X] If a PMI removes a BMI hospital from its network, the PMI continues to benefit from the service and efficiency enhancements which central costs result in for the other hospitals it uses and there is a not a reduction proportionate to the removal of that hospital from the PMI's network in those central costs. The unit price will need to rebalance therefore to redistribute these costs. There is not a simplistic proportional relationship between central costs and the number of hospitals – i.e. removing

¹² The CC has been anxious to reassure BMI that there is no question of confiscation (Letter Pigott/Webber 4 September). This is welcome, although BMI notes that not all PMIs appear to have fully appreciated this point. The CC should take care to keep in this mind when considering PMI support for this approach.

a hospital (through divestment or delisting) does not obviate the need for 1/60th of BMI's central cost as the services paid for through central cost are still required by the rest of the network. The need to rebalance these costs will result in two possible – but not guaranteed - price rises: (i) for the insurer who has delisted the BMI hospital; and/or (ii) other private customers. No increased cost recovery is possible from the NHS as prices are fixed by the Department of Health / Monitor.

24.12 [§]. BMI notes that no insurer, including Bupa, has any actual evidence to offer the CC about BMI's central or regional costs. Their views in this regard should be treated as mere views, not evidence.

24.13 BMI is the country's largest chain of hospitals. It operates by far the largest number of facilities. Hospital chains are significantly more complex than other chain businesses for instance in the retail, restaurant or entertainment industries. Each hospital requires significant support in order to function properly. A chain where many of these functions can be centralised and undertaken by specialist employees is more efficient. BMI notes that Bupa alleges that consumers have not seen any of these 'cross operator' efficiencies as the largest groups "*systematically charge the highest prices*".¹³ This is quite wrong:

- (a) As BMI's response to the CC's insured price analysis shows (attached as Annex 2 to BMI's response to the PFs), the CC's insured price analysis does not in fact show that BMI systematically charges higher prices. There are a number of very serious flaws in the insured price analysis which fundamentally undermine the CC's ability to place any weight upon it. Even on the CC's own case, the insured price analysis is not *evidence* of BMI's alleged market power. It is merely consistent with a conclusion the CC is seeking to evidence using other pieces of analysis¹⁴. The pricing patterns the CC has observed can equally be consistent with other – non-problematic - things such as differences in quality and consumer satisfaction that are key to competition in healthcare. The CC has no way of differentiating between problematic and unproblematic price variation;
- (b) Even to the extent that BMI's prices are in fact higher than its competitors – and BMI cannot know whether this is accurate on the basis of the disclosure it has been permitted - it is grossly misleading to say that the bigger the chain the cheaper the price [§] ought to be. This ignores consumer benefits that derive from chain structures that are non-price related;
- (c) Customer benefits from BMI's efficiently incurred central costs arise as a result of:

¹³ Bupa's response to the Remedies Notice, paragraph 4.146.

¹⁴ PFs, paragraph 6.240.

- (i) Care pathways: the market questionnaire describes numerous examples of BMI's innovation in this regard, including BMI's [redacted];
 - (ii) Support for more and smaller local facilities: BMI is able to operate facilities such as [redacted] that are not viable as independents. When BMI bought [redacted] it did not, as a standalone facility, have even a computerised system for billing, patient records or procurement. All key systems in the hospital were paper-based. Use of BMI systems resulted in a dramatic increase in efficiency, patient safety and experience.
 - (iii) Staff: BMI is able to attract and retain talented staff by offering training and career development opportunities that are out of reach for independent providers. BMI's research shows that clinical staff have the single biggest impact on patients' experience of hospital.
 - (iv) Marketing: BMI has recently relaunched its brand, supporting its roll out and local hospitals through [redacted] is resource intensive but is the principal source of patient and GP interaction before they arrive at hospital. A [redacted] is directly connected to a patient's ability to access information easily and build confidence in BMI as a trustworthy provider of a highly personal service.
 - (v) Patient referral pathways: traditional referral pathways are cumbersome and anachronistic to many patients. BMI has innovated with PMIs to [redacted] The Simplyhealth MSK trial and the AXA PPP Pathways product are key innovations here. [redacted]
- (d) Bupa's prices are also distorted through its own enormous bargaining power vis a vis its competitors. It has an ability to depress the price with a single site hospital below the fair and efficient level, thereby displacing its costs onto other PMIs, the NHS and self-pay patients. Bupa's price cannot be the appropriate competitive benchmark.
- (e) The consumer benefits above are not intermediated by insurers. They reach patients immediately. Recall it is BMI and consultants, not insurers, that deliver care to patients. Patients *actually using BMI's hospitals* therefore experience the improvement in quality, care standards, safety and convenience that these central costs permit;
- (f) Conversely, for a fall in price to Bupa or other insurers to result in consumer benefit, it would have to be passed on. The CC has offered no evidence whatsoever that reductions in price (to Bupa particularly but to other PMIs as well) would reach patients at all. The CC has chosen not to investigate PMIs so has no idea how efficient this market is. Yet there are significant reasons for concern. The PMI market is a slow growing, mature market where even well-resourced new entrants struggle enormously. Unlike the private healthcare market, PMI is

characterised by a single dominant firm whose buyer power gives it a massive cost advantage, as the CC recognises: "*Bupa and AXA PPP obtain much lower prices than the other PMIs, Bupa obtaining lower prices than AXA PPP*".¹⁵ Unsurprisingly, this firm has successfully defended its dominance over a period of decades.¹⁶

- 24.14 One thing that Bupa's view of BMI's central costs and the customer benefits they represent does usefully demonstrate, however, is that there is much scope for dispute over the extent to which increases in central cost coverage can be passed onto PMIs as a result of delisting. How does the CC anticipate dealing with such disputes? Why does the CC believe this will be a materially different and more straightforward undertaking to price control that it rejects at Remedy 8?
- 24.15 Delisting does not only impact local costs. It affects regional and central costs. There is a rationale therefore for what the CC appears to refer to as "cross-operator" volume discount – a term BMI considers to be misleading. Reductions in volume would require these increased costs to be recovered. The extent of this recovery would, almost inevitably, be a matter of dispute.
- 24.16 The costs, delay and difficulty in resolution of such disputes are an obvious disadvantage to the remedy that must be factored into the proportionality assessment. Such disadvantages may well be disproportionate to the aim of the remedy, particularly in the absence of compelling evidence in respect of pass through.
- 24.17 These factors have obvious implications for BMI's ability to react to a delisting using pricing. In addition to those noted above, there are numerous other potentially significant consequences of a remedy that would prohibit a hospital operator from responding to a delisting via price (for example, see paragraph 26.5).
- 25. What does the CC expect will happen to the national price / volume relationship as a result of delisting at a local level? Whose national / price volume relationship does the CC anticipate will change as a result of a delisting decision of a given PMI?**
- 25.1 The CC is well aware that delisting of a hospital has an immediate and severe impact on volumes being treated there for the delisting insurer. This effect is so incontrovertible, even Bupa is prepared to concede it.¹⁷ The CC has also recognised that consultant drag effects amplify the delisting impact into other insured and self-pay work as consultants shift to other hospitals where they can treat all their insured clients.

¹⁵ PFs, paragraph 6.247(f).

¹⁶ See paragraphs 7.4– 7.24 in response to Remedy 1 for a fuller discussion on this "pass through" issue.

¹⁷ Bupa's response to Remedies Notice, paragraph 4.144.

[X]

25.2 [X]

25.3 Consultant drag and general friction in the insurers' referral systems add enormously to the effects of delisting. Many patients were poorly advised by Bupa in the 2011/2012 dispute, communication was slow or not undertaken at all, call centre staff were not properly briefed on hospitals that have been relisted and Bupa refused to communicate relisting in the same way they communicated delisting. This, coupled with the limited interest GPs in particular have for the ups and downs of insurer relationships with hospitals, all magnify the impact of an individual insurer delisting.

25.4 [X]

[X]

25.5 [X] A delisting therefore will have a dramatic effect on cost coverage at a given hospital. In an environment where national pricing to the delisting PMI cannot be affected by this change in the local cost position, the price effect has to occur locally.

25.6 The effect of delisting at a given local hospital therefore must be that average costs at a delisted hospital rise and potentially rise very significantly. If the PMI delisting the hospital no longer uses it they will presumably argue that they do not wish to bear these costs. They will therefore be borne by a combination of BMI and the other remaining private customers of the hospital.¹⁸ Which and in what proportion raises the question discussed at section 26.

25.7 Such a delisting will also remove the volume assumptions that underpinned investment in the hospital (for instance in theatre or ICU equipment and staff). Depending on the volumes removed by the insurer opting to delist, there are likely to also be adverse changes to the hospital offering – including quality range and service implications on other patients who use the hospital as well as price offered to insurers.

25.8 At a dynamic level, of course, the increased risk of delisting will increase the risks associated with hospital investment, increasing the hurdle level of IRR required before an investment is considered worthwhile.

25.9 The CC can therefore expect a remedy that facilitates delisting to rapidly undermine the viability of the delisted hospital or force it to raise its prices to recover costs over a smaller volume.

25.10 It can also expect investment incentives to be harmed and the cost of capital for hospitals to be raised. Both create adverse effects of either less

¹⁸ Again, NHS prices are fixed by national tariff – they cannot respond to changes in BMI costs.

investment or higher prices or both. The CC will need to assess the impact of these adverse effects on consumers if it is to arrive at a rational assessment of proportionality. BMI considers the evidence for likely scale of these effects below.

26. What does the CC believe will be the effect of a sharp decrease in cost coverage as a result of a delisting?

26.1 There appear to be three theoretical options:

- (a) The delisted hospital lowers price (or increases investment) to retain such volume as it can and tempt back the delisting PMI;
- (b) The delisted hospital imposes steep price rises for those PMIs and self-pay patients who continue to use the facility as BMI seeks to recover costs over the remaining volume;¹⁹
- (c) BMI closes the hospital as it cannot cover its fixed costs. An alternative to closure may be a reduction in capital invested, for instance by decommissioning high cost services such as ICU, moving equipment, cancelling earmarked investment.

26.2 To be effective and proportionate, the CC would have to have a reasonable evidence-led expectation based on a rational interpretation of the evidence that 26.3(a) above is the most likely. There are reasons to doubt this would be the outcome:

- (i) [REDACTED];
- (ii) The CC's finding of excessive economic profitability can be seen as driven by the CC's decision to adjust balance sheet values for land and buildings.²⁰ In the "real world" that governs BMI's business decisions, [REDACTED]
- (iii) [REDACTED]
- (iv) [REDACTED] the CC should consider the impact of failures in the PMI market that adversely impact BMI's incentives.²¹ No PMI offers local pricing as far as BMI is aware. On what basis therefore could BMI expect a return from a discount strategy at delisted hospital [y] as a result of lowered local PMI costs? There is no mechanism by which such lower prices locally could drive

¹⁹ There is no ability to change NHS pricing, nor is there any ready ability to switch quickly into servicing NHS demand (PFs, Appendix 6.11, paragraph 241).

²⁰ The CC's other decisions, particularly relating to intangible assets, could also be said to drive the outcome.

²¹ The CC has chosen not to investigate pass through and the efficiency generally of the PMI market. BMI has repeatedly warned the CC and the OFT that this decision was a fundamental mistake and makes a proper understanding of the private healthcare market effectively impossible.

increased local demand; the structure and behaviour of the PMIs means there is no pass-through at all at a local level;

- (v) No PMI is prepared to provide information on pass-through nationally. BMI has no way of assessing whether, and if so by how much, bearing losses in a local market now will payback in terms of future demand;
- (vi) PMIs will not commit to localised marketing campaigns in response to discounts.²² [redacted];
- (vii) Even if pass-through occurred, BMI would not benefit from increased PMI subscription, it benefits from treating more patients. There is a lag between adding policyholders and BMI seeing additional patients – especially if the new policyholders are new to the PMI market or if they are corporate scheme members and need to become accustomed to thinking about their policy benefits when they fall ill;²³ and
- (viii) BMI would therefore expect the pass-through effect of a discount in a local market to be highly diffuse, if discernible at all.

26.3 It is more likely that a sharp decrease in cost coverage in a local hospital will lead to either sharp price rises for the private patients who use the facility or closure. Considering price rises first:

- (a) [redacted];
- (b) PMIs that continue to use the hospital could be expected to resist such price increases – indeed, the commentary of a number of PMIs supporting this remedy does not appear to appreciate this effect at all. Once other PMIs start disputing such price rises, a single delisting event risks generating a feedback loop in any dispute resolution mechanism. [redacted]
- (c) Any dispute would be played out in public as this would strengthen the PMI's hand in a negotiation and weaken the hospital's. In particular, a hospital being dropped by an insurer carries an implication – that [redacted] at least energetically reinforces via its communications strategy - that it is not good enough (rather than the correct evaluation that it is merely not cheap enough in [redacted] opinion). [redacted];

²² [redacted]

²³ Corporate scheme members are often enrolled automatically with an ability to opt-out. This makes PMI a less conscious purchasing decision than other types of insurance, particularly as the employee is very likely to be accustomed to receiving healthcare through the NHS. [redacted]. See marketing information sent to the OFT on 21 April 2011 "GP facing adverts".

- (d) BMI notes that the CC's price prediction from its self-pay PCA analysis is for a 3% price decrease in response to a 20% reduction in market share. The CC considers this price effect to be significant. The CC must therefore consider the likelihood of far larger price effects that would result for self-pay and remaining PMIs from one PMI deciding to delist. This is necessary for the CC to make any assessment of proportionality – specifically whether the remedy will have adverse consequences disproportionate to its aim.

26.4 In respect of closure:

[X]

[X]

[X]

26.5 There are good reasons to doubt therefore that the delisting which Remedy 2(a) appears to promote will prompt positive consumer outcomes. Foreseeable adverse effects include:

- (a) Higher prices for remaining private users. As noted above, this is primarily a function of the financial reality that faces many such hospitals as well as the distortion to hospital incentives that result from poor expectations of pass through by PMIs of discounts offered.
- (b) Substantially increased risk of hospital closures versus the current position.

26.6 The CC must consider these effects if it is to arrive at a rational assessment of proportionality, especially whether the adverse effects are disproportionate to the aim.

27. What are the wider implications of Remedy 2(a) increasing delisting events and hospital closure?

27.1 In addition to hospital-specific effects, the CC would have to consider adverse effects more broadly in its proportionality assessment.

27.2 If Remedy 2(a) promoted hospital exit the CC should expect to substantially raise barriers to entry. New entrants would consider the regulatory risk and uncertainty the remedy poses to their investment return. The remedy would also increase further already substantial volatility in hospital revenue. The remedy would make a hospital provider even more vulnerable to the delisting decisions of the insurers.

27.3 The remedy is likely to reduce pricing certainty for insurers as BMI's ability to offer forward prices declines with insurers' greater incentive to delist hospitals. PMIs benefit significantly from a known forward volume/price curve as they can be confident of the cost advantages of winning new insurance business –

helping in turn the insurer to price keenly to win that business. This ability to commit ahead of time to acquire a certain volume at a certain price is important to being able to price efficiently in the PMI market. Increasing uncertainty and greater volatility of input costs is highly likely to increase premia.

- 27.4 Reducing network predictability increases uncertainty for hospital operators and increases investment risk. It will therefore increase private healthcare providers' cost of capital.

28. Conclusion re Remedy 2(a)

- 28.1 The CC has not properly specified this remedy. However, in exploring the questions above, BMI has illustrated that this remedy is likely to be unworkable, ineffective and disproportionate. The table at the end of this section responds to the CC's specific questions in regards to Remedy 2(a).

29. Remedy 2(b) – the CC proposal

"Would require BMI, HCA and Spire to offer and price their hospitals separately."

- 29.1 As BMI has explained in its evidence, BMI is content to offer, and has in the past offered, pricing that varies by hospital or by local area. See for example [3<]. AXA PPP's procurement exercise in the 1990s, which set the basis of the current pricing structure, has differential pricing by geography. The NHS has (and has had for many years) a market forces factor that adjusts NHS tariff rates by geography.

- 29.2 Any assumption that hospital by hospital pricing has been resisted by BMI for strategic reasons is misplaced and unsupported by the evidence. BMI does not now and has not historically objected in principle to hospital by hospital pricing, just as it does not insist on 'one in all in' contracts.

- 29.3 The reason that hospital by hospital pricing is uncommon is that it increases transaction costs. This has been explained to the CC in detail on many occasions by both private healthcare providers and PMIs.

"National negotiation minimises transaction and contract administration costs for both parties. The complexity of the pricing structures means that a single national price proposition for each line item or procedure increases the ability to negotiate and administer the contract efficiently, significantly reducing scope for negotiation error and subsequent dispute for both sides" – BMI Response to Market Questionnaire.²⁴

"Hospital operators are very keen to maximise their revenue across their whole network. This can be leveraged by insurers through the

²⁴ BMI Response to the Market Questionnaire, section 5, question 31.

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"– AXA PPP Response to Provisional Findings.²⁵

"Aviva does not believe that the CC's proposed remedy 2(b) should be pursued as an alternative to 2(a) as it is unlikely to be any more effective than that remedy and it would be more onerous for both PMIs and hospital operators to implement... Pricing at the individual hospital level could lead to the same outcome as the current market" – Aviva Response to Provisional Findings.²⁶

"The proposed remedy of BMI, Spire & HCA pricing their hospitals separately to PMI's would result in a series of individual tariffs all of which would have to be loaded and maintained on claims adjudication systems. The number of tariffs to be negotiated maintained and updated for PruHealth would increase from 3, to c 125, for these three groups alone. The introduction of multiple tariff negotiations would require an increase in resources (i.e. staffing both at insurer and provider) – and impact most at the smaller insurers, with restricted resources and limited budgets" – Pruhealth Response to Provisional Findings.²⁷

"Simplyhealth believes that [remedy 2b] would be not a practicable option for any other than the two largest PMIs in the market. The scale and complexity involved with hospitals being priced separately ensure that this remedy is not economically sustainable. The immediate consequence, for most PMI providers, would be that significantly higher investments would have to be made into the work force and systems, in order to cope with the increased workload. Simplyhealth believes that the effect on competition would, accordingly, be detrimental, as some providers might have to leave the market altogether, with the consequence that consumer choice would be reduced"- Simplyhealth response to Remedies Notice.²⁸

- 29.4 The reality is that the only market participant that hospital by hospital pricing would advantage is Bupa. They have the volume of episodes in each hospital to be able to negotiate prices from a position of strength – hence local hospital pricing would be strongly to Bupa's advantage. They also have very large teams of analysts and negotiators already in situ. It is likely therefore that

²⁵ AXA PPP Response to the Provisional Findings, paragraph 2.81(3).

²⁶ Aviva Response to the Provisional Findings, pages 6-7.

²⁷ Pruhealth Response to the Provisional Findings, page 8.

²⁸ Simplyhealth Response to Remedies Notice, page 6.

Bupa is already bearing many of the costs that would need to be incurred. These factors help explain why Bupa is the only PMI that has made submissions in support of Remedy 2(b).

- 29.5 BMI agrees with PMIs (save Bupa) that these costs are real. The CC is also correct that the costs of this remedy would fall disproportionately on BMI as it has the largest portfolio. BMI's initial assessment of the data requirements that it would need to consider in order to develop prices on a hospital by hospital basis includes:

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

[redacted]

- 29.6 [redacted]

- 29.7 Likewise, Remedy 2(b) would have the unintended consequence of rendering localised hospital volume discounts highly volatile, as volumes by insurer are highly volatile on a hospital by hospital basis. This reduces pricing certainty and increases underwriting risk for PMIs – which is likely to lead to higher PMI premia.

- 29.8 The CC asks whether prices would be constrained in single hospital areas. Irrespective of the merits and costs of local hospital pricing, BMI believes that there are significant constraints against price rises in any given local areas, particularly those where BMI has a high market share. This is consistent with the evidence that BMI submitted that showed self-pay prices at solus hospitals were not indicative of BMI exploiting its market position in these areas:

- (a) The CC's PCA and BMI's solus paper (properly interpreted) both demonstrate that there are no compelling price effects in self-pay as a result of local pricing for solus, cluster or duopoly hospitals.²⁹ Even if

²⁹ See "Do private healthcare providers have market power in solus hospital markets?" (prepared by Compass Lexecon), dated 11 January 2013; and "Comments on the Competition Commission's Price Concentration Analysis" (prepared by Compass Lexecon), dated 20 May 2013.

this could be simply “read across” to PMI, which it cannot, there is no evidential basis to suggest that prices to PMIs will rise in areas of high concentration if hospitals charge on the basis of their local competitive position;

- (b) Reputation will very strongly constrain price rises. This effect is much more pronounced for PMI pricing than for self-pay. [X] That the CC’s ultimately desk-based assessment of competition suggests that (in the CC’s view) BMI ‘could’ raise price in Aberdeen, Kings Lynn or even Chertsey following a local pricing remedy, does not mean that is possible in practice. Indeed, if BMI attempted to do so – even assuming the CC’s competition assessment is correct which it mostly is not – BMI would expect to suffer a severe backlash. [X].
- (c) BMI negotiates opposite sophisticated and professional buyers. In particular, Bupa, AXA PPP, Aviva and Pruhealth, which together account for [X] of BMI's insured volumes and [X] of BMI's insured revenues in 2011, are all far larger and have access to more resources than BMI does. [X]
- (d) Prospects for entry in response to high prices are good:
 - (i) Entry can be tailored to the market opportunity. The CC accepts barriers for outpatient and day case are low. Entry at this scale alone would introduce competition for, on average, [X] of the volumes treated at a given hospital;
 - (ii) Hospitals quickly reach efficient scale – see BMI's response on barriers to entry (attached as Annex 5 to BMI's response to the PFs);
 - (iii) PMIs have the ability and incentive to sponsor new entry; and
 - (iv) BMI has no ability to "induce" a PMI not to recognise a new entrant as the case study in Bath demonstrates.

29.9 Remedy 2(b) as stated therefore would add significant complexity to negotiations and costs both to BMI and PMIs. There is no demand for it from PMIs (excluding Bupa).

29.10 BMI notes and agrees with the comments of Bupa's competitors which warn the CC to be careful to avoid conferring yet further advantage on Bupa which alone supports this remedy and have most to gain from its implementation.

30. **Remedy 2(c) – Required Alteration to CC Tying and Bundling Proposal**

30.1 Any remedy that intervenes in the agreement between hospital providers and PMIs to favour PMIs will be effective only if its benefits are passed on to consumers. As discussed throughout this response, this in turn depends in

great part on the effectiveness of competition in the PMI market. BMI explains its view in respect of this important "pass through" question above.

30.2 Leaving to one side the effectiveness and proportionality of the CC's Remedy 2 proposals, BMI considers that if the CC is to intervene in agreements between hospital providers and insurers in any way at all, it must ensure that those agreements do not contain offensive provisions that are likely to distort competition in the PMI market and hence reduce the effectiveness (if any) of pass through.

30.3 As a simple modification to any tying and bundling remedy, therefore, the CC ought to prohibit PMIs from imposing non-compete or similar obligations on PHPs in their agreements that restrict that hospital operator from working with other insurers in any way. [redacted]:

[redacted]

30.4 In December 2011, BMI publicly criticised Bupa suggesting that policyholders may want to switch insurer. [redacted]. Bupa also made public announcements rejecting the suggestion that anyone might switch away from them as both "*misguided and ridiculous*". Bupa's MD at the time explained that due to the pre-existing condition clauses in PMI policies Bupa's existing customer base was captive.³⁰ It was therefore "ridiculous" for BMI to suggest that Bupa's customers had the ability to switch insurer. In our view this extraordinary statement illustrates rather well the sense of entitlement that typically characterises firms in a longstanding dominant position as well as the features of the PMI market that cause adverse effects on competition.

30.5 [redacted]

30.6 [redacted]

³⁰ Dr Natalie-Jane McDonald, Managing Director of Bupa, Health and Wellbeing Interview with *Health Insurance*, available at <http://www.hi-mag.com/health-insurance/product-area/pmi/article385126.ece?page=2>.

BMI's response to the CC's Remedies Notice (Remedy 2)

Remedy 2(a) - 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.

(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?

The remedy is poorly specified so it is unclear exactly what the CC is seeking to achieve. That said, as developed in the discussion above, BMI considers that it is unlikely that this remedy would be effective - see paragraphs 20.1 to 28.1.

(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?

No intervention on this scale should come into effect until the end of the current contracts. Given the lack of certainty around key elements, the potential for harmful disruption to patients and the need for each of BMI and insurers to adjust their contractual and commercial position to the new contracts. [§<].

(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?

The remedy is plainly unreasonable. See sections 18 to 19 and 20 to 25.

Hospital operators have grounds for seeking a price increase from a PMI in the event that the PMI reduces the amount of business it does with an operator:

- Some PMIs opt to procure private healthcare services on the basis of exclusive or tight networks, for lower prices. [§<] – see sections 22 and 23.

Banning operators from adjusting price to reflect reductions in volume would incentivise PMIs to overpromise and under deliver volume, undermining BMI's basis for offering volume discounts (see section 24).

The effect of PMI delisting is that average costs at a delisted hospital rise significantly (see section 25 of this part), resulting *potentially* in sharp price rises or closure (see section 26 of this part).

Delisting impacts local and central costs. Reductions in volume would require these increased costs to be recovered. If national pricing cannot be affected by the increased costs arising from a PMI delisting, then the price effect must occur locally and will likely be significant. See paragraphs 24.10 to 24.16.

Although no pass-through assessment has been undertaken, there are strong reasons to believe that pass-through will be more effective for the smaller insurers and that given the scale of the cost advantage that Bupa and AXA PPP benefit from, it is unnecessary for any remedy to confer benefit on Bupa and AXA PPP in order for it to be equally effective. Remedy 2(a) can readily be applied to insurers below a certain size. As such the CC must select the least onerous of two equally effective remedy options.

(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?

Yes. This remedy is likely to generate disputes between operators and PMIs – see paragraphs 26.3(b) to 26.3(c). These will need adjudication.

[X].

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

None.

Remedy 2b - require BMI, HCA and Spire to offer and price their hospitals separately.

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

There are a number of significant practical hurdles.

Hospital by hospital pricing increases transaction costs – see paragraph 29.3.

The cost of this remedy would fall disproportionately on BMI. To develop hospital by hospital pricing, BMI would need to assess the numerous factors listed in paragraph 29.5. As noted, the market participant that is most likely to benefit from this remedy is Bupa. The CC has no evidence that pass through would occur. Pass through is likely to be highly inefficient in respect of benefits conferred on Bupa.

Remedy 2b would add significant complexity and costs to BMI and PMIs – see paragraphs 29.3 and 29.5 to 0.

[X].

[X].

(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?

No intervention on this scale should happen until at least the end of the current contracts. The disruption and change that would be required to BMI and the insurers pricing models and negotiation would be so significant it would take until at least the next contract review. It is impracticable to think that this can be imposed by the CC any earlier.

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

Reputation and other relevant factors would strongly constrain price rises – see paragraph 29.8.

(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?

Prospects for entry commensurate with the market opportunity created in response to high prices are good (see paragraph 29.8(d)).

(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?

Yes – it is likely that Remedy 2b would lead to unintended consequences including highly volatile localised hospital volume discounts, resulting in higher underwriter risk and PMI premia (see paragraph 0).

Hospital closure is a material risk. It self-evidently results in consumer detriment by reducing choice and local provision.

(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?

No. There is no evidence for this concern. BMI does not have the ability to induce a PMI not to recognise a new entrant (see paragraph 29.8(d)(iv)).

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.”³¹

31. (a) *Would the remedy be effective?*
- 31.1 The remedy seeks to reduce barriers to entry by reducing competition for PPU tendering opportunities.
- 31.2 BMI wonders whether the CC contemplates, by inference, that a PPU operator would be prevented from opening a local private hospital?
- 31.3 The remedy is unnecessary as the CC's analysis of barriers to entry is insufficiently robust to support the provisional finding that high barriers to entry are a feature of the private healthcare market.
- 31.4 That said, and without prejudice to this view, BMI accepts that in principle this remedy would be both effective and proportionate at resolving any AEC that were found to result from high barriers to entry and weak competitive constraints in many local markets.
- 31.5 A key advantage this remedy has over the CC's other remedies involving Remedy 3 divestment and interference in contractual freedom is that it is focused on barriers to entry. Unlike Remedy 2, the remedy directly addresses the underlying feature the CC has supposedly identified, rather than just the adverse effects arising from the feature.
- 31.6 PPU outsourcings are a likely source of significant growth as they have a number of key advantages over new build facilities. PPUs require a lower capital outlay. All PPUs sit on the existing site of an NHS Trust (or NHS Foundation Trust) with access to this pre-existing infrastructure and will to a greater or lesser extent share the facilities of the Trust. This reduces the amount of sunk and fixed costs a private hospital operator has to invest in order to establish a presence in a market. It also makes the recruitment of consultants far easier. Consultants will invariably have a substantive NHS post. To then undertake their private work they generally have to travel to a different hospital. PPUs allow consultants to treat private patients while remaining at their NHS site; this is not only more convenient for consultants as they do not have to split their practice but means they always have access to the wide-ranging resources of the NHS, including specialist equipment and surgical and support staff to which they are accustomed.
- 31.7 The CC must have regard to the proportionality of each of its proposed remedies. As explained above, the CC's proposed divestment remedy is

³¹ Remedies Notice, paragraph 56.

highly disproportionate in terms of its: (i) scale [§<]; (ii) removal of efficiencies; (iii) [§<]; (iv) confiscatory nature; (v) introduction of double jeopardy into UK regulatory risk; (vi) disruptive effect on patients; and (vii) scope (both its impact on non-privately funded inpatient work and privately funded inpatients who will not benefit from divestment). The CC guidance on remedies states:

“344. In making an assessment of proportionality, the CC is guided by the following principles. A proportionate remedy is one that:

(a) is effective in achieving its legitimate aim;

(b) is no more onerous than needed to achieve its aim;

(c) is the least onerous if there is a choice between several effective measures; and

(d) does not produce disadvantages which are disproportionate to the aim.

345. Applying these principles to the circumstances of particular cases usually involves consideration of remedy options both relative to other effective measures as well as relative to taking no action”³²

The CC must therefore weigh the proportionality and effectiveness of each of its proposed remedies. When compared to the CC’s proposed divestment it is clear that remedy 3 would be much more effective in achieving the CC’s aims, not least because the CC has no rational basis to consider remedy 1 itself to be effective or proportionate in relation to its own adverse effects (i.e. category (d) above). Remedy 3 would also be far less onerous on hospital operators, who would not be required to sell large parts of their businesses [§<], undermining on-going commercial strategies and removing efficiencies from the businesses and also far less onerous for patients. Remedy 3 is significantly less onerous than remedy 1 or remedy 2. However, the CC must address the issues below if this remedy is to be workable.

(a) [...] In how many and which Single or Duopoly areas is it likely that PPU will be launched?

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

31.8 Remedy 3 requires some further thought and clarification before it would be workable.

[§<]

³² CC3 Guidelines for market investigations: Their role, procedures, assessment and remedies, paragraphs 344 and 345.

- 31.9 PPU's are an excellent and common opportunity for hospital operators to establish a competitive presence in a local market, particularly in their ability to allow the hospital operator to enter on a scale to meet local demand. It is therefore attractive to form a PPU partnership in an area in which a hospital operator does not already operate a hospital. BMI has considered the feasibility of taking over a PPU on a large number of occasions, overwhelmingly in areas where it does not already operate a hospital.
- 31.10 BMI is not in a position to answer how many PPU opportunities will arise in Single and Duopoly areas. For one thing BMI does not understand how big these areas are or how their boundaries are defined. That said, we note that there are NHS Trusts and NHS Foundation Trusts in or around all of these areas and there have been a large number of tenders over the past six years. Further, with the introduction of the Health and Social Care Act 2012 (the "2012 Act") raising the cap on revenues Trusts can receive from private patients, it can be expected that the number of PPUs will only increase in the coming years. BMI again notes the information obtained under Freedom of Information Act 2000 by Gareth Thomas MP (Lab - Harrow West) and reported in the Guardian in April 2013.³³ This stated that a large number of NHS Foundation Trusts had ambitious plans to grow their private work as the previous cap on private income is removed by the 2012 Act. Importantly this trend is not restricted to specialist centres of excellence in London:

"Beyond the centres of excellence, such as Great Ormond Street hospital, these trends have encouraged smaller trusts to seek extra funds. Ealing hospital in London – which is facing the closure of its A&E department – has budgeted for a 231% increase in private patient income in 2012-13 as against 2010-11, albeit from a low base. The Surrey and Sussex trust has budgeted for a 186% increase."

"Of the country's 146 foundation trusts – each of which has a significant degree of financial autonomy – 40 plan to open private patient units."³⁴

- 31.11 The table below, provided in BMI's response to MQ, Q68(e), details the PPU opportunities for which BMI has tendered in the last six years and includes the tendering Trust, the stage of the process that BMI reached and the final result. The scale, geographic variation and number of these opportunities is clearly significant. This list refers to tender opportunities before the 2012 Act era.

[X]

- 31.12 More recently, HCA has been successful in tendering for a PPU at the University of South Manchester NHS Foundation Trust, due to open mid-2015 and only 12 minutes' drivetime from BMI Alexandra. The new facility will include approximately 40 IP beds and a 6 bed ITU to CCL3. There will also

³³ BMI response to AIS, paragraph 4.32.

³⁴ <http://m.guardian.co.uk/society/2013/apr/06/nhs-hospitals-increase-private-patients>

be 2-3 theatres with cardiac catheterisation and hybrid capability, together with MRI (3T) and CT diagnostic facilities. Not only will the services provided include all existing Trust specialties, but it is expected the PPU will bring high acuity/high complexity services which will be new to South Manchester and also some services not previously available in the private sector outside London.

31.13 There are also legal issues the CC must consider carefully before it adopts this remedy in its current form:

- (a) The CC will have to ensure that its intervention is compliant with EU procurement rules that apply to the selection of PPU partners by Trusts;
- (b) BMI considers that this remedy would be more effectively and proportionately introduced by bringing such tenders within the existing merger control regime. This would not require any change to the statutory arrangements although the decision of the OFT re. Guy's and St Thomas' NHS Trust could be considered a hurdle in this regard,³⁵ and
- (c) The CC could make a joint statement with the OFT (or by itself or as the CMA) that it considers a PPU outsourcing contract where the Trust agrees to contribute any private revenues it currently generates (including by way of a non-compete obligation) to the PPU would mean that the PPU outsourcing constitutes an "enterprise" within section 23 of the Act. The vast majority of Trusts generate some private revenue – even if this is not within an existing PPU and would usually roll this into an outsourcing deal for instance through a non-compete provision. This is both consistent with the usual interpretation of the Act and avoids the misperception that Guy's and St Thomas PPU creates a precedent that PPU outsourcing is outside UK merger control.

(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?

31.14 Any restriction on a Trust's ability to select a partner could result in the trust achieving a less attractive financial arrangement than it may otherwise have done.

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

31.15 The restriction should apply only to the first procurement that a Trust runs. Where that first procurement is unsuccessful (for example there are no other

³⁵ No. ME/5641/12, paragraph 20, see http://www.of.gov.uk/shared_of/mergers_ea02/2012/HCA.pdf.

compliant tenders) the Trust should be permitted to run the tender in an unrestricted way. If the incumbent is then willing to provide a tender that is fully compliant and meets all the relevant evaluation criteria (excluding the effect of this remedy), it should be permitted to enter into the arrangement. This is on the basis that if the only way to secure the required investment, development of facilities and expansion of services as well as income stream for the NHS, in a local area is to allow the incumbent to tender and share scale / scope efficiencies from its other operations in the local area with the NHS, then it would be perverse for patients to be denied the benefit of such investment.

(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?

31.16 There are a number of issues concerning implementation and monitoring of the remedy that must also be considered, including:

- (a) What would be the relevant methodology for determining a local area? The CC would have to clearly outline which markets it considers to be Single and Duopoly. Obviously BMI and others must be permitted an opportunity to comment on this ahead of implementation. What would be the methodology for determining the precise geographical extent of these and which hospital providers would be precluded from tendering for PPUs in each area? Would the size of the local area be a function of inpatient admissions, hospital capacity, or some other metric or combination? In the interests of certainty, the CC should consider specifying in advance which Trusts it wishes to restrict from running full tender processes and which providers the CC intends to disqualify from which tender processes *ab initio*. This provides Trusts with certainty, reduces prospects of disputes and avoids incumbents wasting bid and other costs.
- (b) There would have to be a process for on-going assessment and if necessary modification of the classification or specifications of Single and Duopoly markets to take into account new entry and expansion or hospital closure. This could be done (most likely) by way of self-assessment or (alternatively) by an independent body (in this case, Monitor would likely be the most appropriate choice). In either case, there must be a set of clear and objective rules and criteria for delineating local areas and determining which hospital operators would be precluded from tendering for PPUs in that local area. If an independent body would be responsible for undertaking this on-going review it would have to abide by an established process for clearly and effectively communicating which hospital operators are precluded from tendering for any given PPU. Further, even if the self-assessment strategy would be preferred, the involvement of an independent body would be required for oversight and enforcement of disputes.

- (c) The remedy would anyway have to be subject to a sunset review after a period. BMI considers that, given the process of change ongoing as a result of the 2012 Act, this sunset review should occur after a relatively short period. BMI suggests three years.

REMEDY 4

RESTRICTIONS ON CONSULTANT INCENTIVES

32. Remedy 4

32.1 BMI has made its position on consultant incentives clear to the CC on many occasions, including at its hearing earlier this year. BMI does not consider there is a compelling competition case to prohibit these schemes, [X].

32.2 The CC has provisionally found that the existence of incentive schemes operated by private hospital operators which encourage patient referrals for treatment at their facilities are a feature of the market which gives rise to an AEC.³⁶ From a competition perspective, this conclusion is unfounded and wrong but BMI is content to see a remedy implemented as it believes patients would be better served without such schemes.

(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?

(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?

32.3 The CC draws a distinction “*between schemes which provide a short-term reward whose value will be directly affected by the conduct of an individual consultant, for example fee per referral schemes, and longer-term incentives, for example equity participation schemes, whose value will depend on the conduct of the generality of participants in the scheme.*”³⁷ The CC however then states that “*it would be very difficult to draw a clear distinction between the two types of scheme: a shareholding by a small number of consultants in a specialist clinic, for example, could mimic the effects of a fee per referral type scheme. We concluded that private hospital operators should be precluded from entering into either type of scheme.*”³⁸

32.4 BMI agrees a distinction must be made between (a) incentives purely for referrals; and (b) equity investments with consultants. BMI does not agree that a ban should be imposed on both types of arrangement.

³⁶ Remedies Notice, paragraph 58.

³⁷ Remedies Notice, paragraph 59.

³⁸ Remedies Notice, paragraph 60.

- 32.5 Equity participation “schemes” is a misleading term. Joint ventures would be a better and more accurate description. There is no good competition rationale – and certainly no evidence offered by the CC – to support the suggestion that co-investment by complementary service providers in capital equipment, a new facility or in a new service in a joint venture should be considered anti-competitive. Indeed such a sweeping conclusion would be very odd. Competition authorities are generally sympathetic to joint ventures and require a case-by-case analysis.
- 32.6 Furthermore, the categorisation *ab initio* of some “equity participation schemes” as giving rise to an AEC while others do not is unworkable, misguided and risks *uncompetitive* outcomes, such as encouraging inefficient entry while at the same time discouraging investment and innovation to benefit patients. The remedy as described is transparently designed to favour Circle’s business model. This is absolutely inappropriate and unlawful. Any remedy must be driven by the principle of addressing an AEC, not by a desire to benefit a favourite player in the market.

Incentives purely for referrals

- 32.7 BMI [X] the CC’s plans to prevent these schemes. [X]. BMI does not see any reason why the prohibition on entering into new agreements of this nature should not be immediately effective. [X].
- 32.8 BMI agrees that the provision of certain facilities to assist consultants with their practices (e.g. consulting rooms) should not be prohibited if it could be demonstrated that they were being charged a fair market price. The CC’s guidance on what constitutes a market price would be welcome to improve certainty for both providers and consultants. In relation to insurance, BMI considers that commercial insurance policies, paid for by PHPs and which cover consultants treating NHS patients, are not ‘incentives purely for referrals’ and should not be treated as such. There are several reasons for this including the need to ensure there is a level playing field for all those providing NHS services (both PHPs and Trusts) and that PHPs (or indeed Trusts) opting to take out commercial insurance rather than join the Clinical Negligence Scheme for Trusts are not unfairly prejudiced. However, BMI does not consider the position in relation to PHPs (or indeed Trusts) paying for insurance cover or indemnity arrangements to cover consultants’ *private* practice to be the same and considers any such practice should be prevented.
- 32.9 BMI would also welcome a *de minimis* provision to provide certainty for hospital operators that small benefits, such as the printing of letterheads, a limited period of free consulting space for newly appointed consultants, inclusion of consultants’ details in consultant directories, websites and other information and marketing materials and introducing consultants to GPs and other referrers would not constitute a breach of the prohibition. BMI would consider a *de minimis* threshold of £2,000 to be appropriate. To be clear, BMI does not consider payment of a consultants’ insurance premia or similar for

their private practice to fall within the concept of ‘de minimis’ as this is not an incentive at all.

- 32.10 This prohibition must be absolute. There is no basis whatsoever for equity participation schemes or joint ventures to contain any referral commitments. An equity investment would already give a consultant an incentive to use the facility that he or she has invested in; minimum referral commitments risk breach of GMC guidance. By excluding such schemes from the prohibition on incentive for referrals, the CC would create a huge advantage for a new entrant (who would be able to sign up consultants with incentives in exchange for referrals) whereas an incumbent would be unable to meet this competition. There is no lawful basis for such discrimination in favour of new entrants over incumbents.

Equity Investment

- 32.11 The CC should not prevent equity investments with consultants. These are not consultant “incentives” in any normal sense at all. BMI notes the CC has included a caveat, preventing such schemes “*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.*” This distinction is misguided. Bare equity investment, without an explicit requirement for referrals, is not generally harmful to competition – and, at the very least, would require a case-by-case assessment. The distinction is also unworkable in practice. However, referral incentives dressed up as equity clearly need to be prohibited and BMI is highly supportive of this.
- 32.12 First, it is unclear what the CC means by ‘new entry’ and how this would be decided in practice. It is absolutely clear that ‘new entry’ must not be understood in a full service i.e. Circle type sense. Equity investments can be (and often are) used to support, expand and develop consultants’ practices - and specialties - at an incumbent hospital. These should qualify. They perform precisely the same competitive function as new entry. The CC has no principled basis on which to limit the exception to “full service”
- 32.13 The CC must recognise that such agreements support hospital investment, bring innovation to the market and enhance clinical and service quality and efficiency. If they are not therefore exempt from the remedy, then the remedy fails to recognise the broader range of equity investments with consultants that are also pro-competitive. This could prevent investment that could lead to direct benefits for patients. The distinction would be irrational when pro-competitive benefits can be offered by both types of joint venture / equity participation agreements.
- 32.14 Second, the CC’s proposal requires “*a reduction in barriers to entry that is likely to be at least as beneficial to competition as any distortion is harmful.*” This is at the heart of firms’ self-assessment under Article 101 TFEU / Chapter 1 Competition Act 1998. Any monitoring or supervision of this outside those

rules would be plainly unworkable and risk infringing the UK's obligations under Article 3(2) Regulation 1/2003.

- 32.15 Third, the CC has presented no evidence that joint ventures / equity participation schemes between BMI and consultants have in any case distorted competition. This is even less likely to be the case after the prohibition of referral schemes. Consultants are free to hold practising privileges at different hospitals. If they believe it is in a patient's best interests to be treated at an alternative facility then they are free to make that recommendation. Equity participation schemes do not require a consultant to refer a patient to any particular facility and they are free to make this decision based on their own clinical judgment.
- 32.16 Fourth, the distinction, so far as it takes a narrow view of 'new entry' is undesirable as it would create an unhealthy and uncompetitive disparity in the positions of an incumbent and a new entrant to succeed in the market and raises the question when a new entrant is no longer a 'new entrant'. The CC must ensure parity of treatment. It is not rational to allow one hospital operator to offer incentive schemes while another has no ability to do so for the sole purpose of encouraging new entry. There is nothing to suggest such disparity would benefit patients. The benefits accruing to patients from equity investments can arise from the use of such schemes by both new entrants and incumbents. If an incumbent hospital develops new or enhances existing treatment capabilities as a result of threatened entry then this is an example of a pro-competitive development in the market. Yet the CC's remedy envisages prohibiting such action. It may therefore mean that no investment is made at all, should the potential new entrant decide not to proceed. This would be directly harmful to patient interests. The solution to this lies in permitting equity participation for all investment whether by new entrants or incumbents.
- 32.17 Fifth, the CC has recognised that the negative growth of the PMI market inhibits new entry. Where cases of inefficient entry arise, the CC must allow the outcome to be determined by competition between the hospitals. The CC's Bath case study is an example of inefficient entry. The CC should be absolutely clear that Circle's failure is a consequence of their poor commercial judgment. The CC must not (and lawfully cannot) seek to 'rig the game' to guarantee one hospital's (e.g. Circle's) success at the expense of the other (e.g. BMI's). That is the antithesis of competition. The entry of Circle Bath has burdened an already over-served market with the additional costs of unwarranted provision, [X]. While unwarranted entry followed by market correction is undesirable (being detrimental to patients by increasing costs, creating unnecessary disruption and misallocating capital), where it occurs, competition alone should determine [X].
- 32.18 Sixth there are a number of successful hospital/consultant JVs in operation across England.³⁹ If the CC prohibits such agreements, many of these may

³⁹ Details of BMI's JVs were provided in response to the Market Questionnaire, Section 8, question 49.

have no alternative but to close, [§<]. In the complete absence of any evidence that extant joint ventures have caused harm, requiring them to be unwound would be grossly disproportionate in that the adverse effects would be disproportionate to the aim.

32.19 BMI is supportive of rules obliging hospitals and consultants to be completely transparent to patients about any joint equity investments and is happy to work with the CC regarding how this may most effectively – and universally - be done. BMI is also supportive of rules prohibiting clauses in agreements which encourage, compel or otherwise incentivise consultants to bring their practice to any hospitals or JVs in which they may have an equity interest. Prohibition of this type of provision is front and centre of this remedy – without which it cannot work. Subject to these measures and so long as patients are referred on the basis of a consultant's clinical judgment, guided solely by the best interests of each patient, there is no reason why joint ventures /equity participation schemes cannot be a pro-competitive feature of the market as they are in virtually all other capital intensive markets.

32.20 The CC must ensure that equity investment is not in reality a referral incentive. The investment risk for consultants needs to be real, so that consultants cannot be "loaned" the investment, and the return needs to be proportionate to their investment.

(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 commercial relationships between healthcare facilities and clinicians and their introduction?

32.21 BMI has no experience or direct knowledge of the Stark Law and so is unable to comment in this regard. As a general remark the UK healthcare context is very different from the USA making transplantation of American models difficult.

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

32.22 It would absolutely be necessary to grandfather existing arrangements. BMI refers to paragraphs 32.3 to 32.19 of this part above.

(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?

32.23 BMI refers to paragraphs 32.3 to 32.19 above.

REMEDY 5

A RECOMMENDATION TO THE HEALTH DEPARTMENTS OF THE NATIONS

33. Remedy 5

“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”⁴⁰

The CC notes, in December 2012, NHS England announced plans to collect and disseminate performance data for individual consultants in ten medical specialties and that the provision of this information to patients would be sufficient to provide a solution in England to this aspect of the AEC that we had provisionally identified.

The plans do not however extend to the rest of the UK.”

33.1 BMI fully supports the adoption of Remedy 5.

(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?

BMI considers it appropriate that the publication of performance data should cover the entirety of that consultant’s practice, irrespective of the nation in which the consultant practises. This is to ensure that this remedy – and the proposed publication - fulfils its role of providing transparent (and therefore complete) information about a consultant’s performance.

(b) Is the proposed list of ten specialties⁴¹ for which performance data will be available on an individual clinician basis appropriate?

(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?

⁴⁰ Remedies Notice, paragraph 69.

⁴¹ See <http://www.england.nhs.uk/wp-content/uploads/2012/12/everyonecounts-planning.pdf>

(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?

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

REMEDY 6

AN INFORMATION REMEDY

34. Remedy 6

“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.”

- 34.1 Whilst BMI does not necessarily believe that deficiencies in this area are sufficient to establish an AEC, BMI fully supports a remedy designed to provide patients with clearer and more comprehensive information on consultant fees and will work closely with consultants to ensure these objectives are achieved.
- 34.2 Patients attach significant importance to the transparency of the costs of treatment. The CC must ensure that published information does not inadvertently have the effect of misleading patients about the overall (i.e. including also non-consultant) costs of treatment. It is obvious this would be counter-productive and only exacerbate the existing dissatisfaction felt by patients at the lack of pricing transparency.
- 34.3 It is therefore important that patients understand the information published and that they are fully aware of any limitations to it. To this end, BMI notes that a consultant's fees, in isolation, will be poorly correlated with the total cost of a patient's treatment (and that a consultant's initial consultation fee will almost certainly bear no resemblance to the overall cost of treatment). Rather, the total cost will be affected by variable costs such as the surgeon's choice regarding the number and type of investigations and, if proceeding to surgery, the anaesthetist, etc. These additional costs increase the total cost incurred by a patient substantially and patients should be fully aware of this.
- 34.4 Having said that, we note the proposed remedy is directed towards the publication of the charges of consultants' initial consultations, with details of the proposed cost of any treatment to be provided to patients in advance. Some procedures are carried out in an outpatient setting and indeed at a first outpatient appointment – such as some ENT or minor dermatology procedures, but BMI considers it should be possible for consultants practising in such specialties to provide at least a range of costs of any such procedures which might – where clinically appropriate and only with patient consent, both medical and financial – be carried out at an initial consultation. Guidance – developed perhaps in conjunction with the GMC – on how best to ensure patients receive full information on proposed cost, but at the same time are not put to further expense by being required to wait until a subsequent appointment to have a procedure - would be helpful to ensure an appropriate

best practice standard is defined. This could include standard wording advising patients to check coverage and any sub-limits within their policy.

34.5 As noted in paragraph 34.3 above, it is also critically important that patients are aware the consultants' charges are only part of the charge which will be made to patients. Nonetheless, it is important that the objective of providing patients with clear information on charging without compromising a smooth and efficient care pathway for patients is met and BMI is supportive of this proposed remedy.

34.6 BMI considers the requirement to provide clear, transparent pricing information should apply to all consultants practising in the private sector, not just those earning above a certain level. In addition – and as noted above – we believe the input of the General Medical Council to assist in describing what constitutes 'good medical practice' in this area would be helpful.

(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?

(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?

(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?

(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?

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

REMEDY 7

AN INFORMATION REMEDY

35. Remedy 7

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.”

35.1 BMI does not believe the lack of sufficient public information on hospital performance and consultant performance and fees are sufficient to establish an AEC on their own.

35.2 However, BMI is fully supportive of initiatives to provide patients with clear and comparable information on consultant performance indicators, consultant fees and hospital quality.

35.3 The CC, OFT and Monitor in their recent joint statement have emphasised the importance of quality competition in healthcare. It is:

“Choice for patients and commissioners and competition between hospitals to attract them helps ensure healthcare providers have incentives to improve the quality and efficiency of their services.”

35.4 Information particularly around quality metrics in healthcare is essential to the competitive process. Improving the flow of information to patients, GPs and to a lesser extent insurers, will facilitate competition and improvements in patient outcomes.

35.5 The AECs the CC claims exist in the market would appropriately be characterised as long-term and structural in nature. In its guidance, the CC states “[t]he more an AEC reflects longer-term and structural problems within a market, the greater the significance the CC is likely to accord to the long-term development of competition in the market and to the less quantifiable consequences of an improvement in the competitive pressures in the market.”⁴² Such AECs therefore call for remedies that focus on the long-term development of competition in the market. The CC’s information remedies – far from being the last on a list of options – are the most appropriate and most significant for driving long term change that will lead directly to the improvement of competition in the market. Increasing access to relevant information on hospitals will enable patients to make more informed choices about the treatments and care they choose to receive. This will directly drive competition between hospitals, thus improving clinical standards and quality of care.

⁴² CC3 Guidelines for market investigations: Their role, procedures, assessment and remedies, paragraph 351.

35.6 Further, the CC notes that “Customers have an important part to play in stimulating rivalry between suppliers by making informed decisions which reward those firms that best satisfy their needs or preferences. Markets work best when both the supply side (the firms) and the demand side (the customers) interact effectively.”⁴³ The CC’s information remedies will be far more effective at improving long term competition in the private healthcare market and addressing the long-term and structural AECs the CC claims exist in the market as these information remedies focus directly on the central issue of stimulating competition by empowering customers to make more informed decisions.

35.7 The effectiveness and proportionality concerns associated with remedy 1 and 2 are so profound that far greater consideration must be given to the ability of information remedies to act over the long term. The CC must dissociate the pressure from parties who have a strong self interest in seeing remedy 1 and 2 be implemented from the interests of patients – who are unrepresented in the inquiry.

35.8 BMI recognises - and has recognised for a long time - the need to make available to patients easily comparable information relating to hospital quality. BMI therefore fully supports the CC’s proposals requiring private hospitals to publish data equivalent to that provided by the NHSs.

(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?

(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?

35.9 The remedy is certainly practicable and significant progress is already being made to increase the scope and depth of data patients will have at their disposal to compare hospital performance. In particular:

(a) BMI collects data equivalent to that captured in the HES database, which is then published on PHIN. This includes key performance indicators such as length of stay, day case to overnight stays, unplanned readmissions, MRSA and C Diff rates and mortality rates.

(b) BMI collects PROMs data for NHS patients undergoing hip and knee replacement, varicose vein surgery and inguinal hernia repair. BMI has made efforts to extend PROMs reporting to private patient episodes.

⁴³ CC3 Guidelines for market investigations: Their role, procedures, assessment and remedies, paragraph 12.

- (c) BMI provides additional clinical quality data as requested by PMIs, e.g. Bupa's quarterly clinical indicator report and for CCGs. This is done in respect of both NHS and private patients, as required.

35.10 BMI supports the CC's proposals to make such reporting mandatory for all private hospitals through the publication of such information and believes this could be achieved within a 12 month timeframe

(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?

35.11 The CC must be specific as to what data is required, for example there are potential discrepancies in the scope and granularity of data published by each of the NHSs, and reporting requirements will necessarily change over time. BMI suggests the CC appoints an independent body to which the information should be made available, charged with the responsibility of specifying and updating precisely what information is required to be published to comply with Remedy 7. This body should also be responsible for making the information accessible to the public and for monitoring compliance.

35.12 PHIN is the most appropriate body to perform this role. PHIN has already established a platform specifically for the publication and exchange of clinical and public health data. PHIN shares the objectives of giving patients easy access to clear and comparable information on hospital activity and quality of outcomes. Development of this platform therefore seems logical. BMI notes that PHIN has already indicated that it is both well placed and willing to perform this role.⁴⁴

35.13 BMI would also support providing further data on a wider list of specialisms and procedures, so long as this is done within the framework provided by PHIN. However, any extension to the reporting requirements must be carefully considered; some procedures are not carried out in sufficient volumes to provide patients with robust data on which meaningful trends and comparisons can be made. Publication of such data could therefore be actively misleading and would not be in the patients' best interests should they use it to make comparative assessments. Clear rules should be put in place governing thresholds for when reporting could extend to new specialisms, or alternatively how these concerns could be addressed so the limited data could be effectively published. A particular concern is that in practice the reporting requirements could apply unequally across the market, with patients being unable to compare the performance of smaller hospitals due to insufficient volumes of data being available.

35.14 BMI is supportive of changes that will empower patients to make better informed choices regarding their care. In order to be effective, these

⁴⁴ PHIN response to Remedies Notice.

standards would have to apply industry-wide, so comparisons could be made between all hospitals on the basis of uniform data. In order to be practical, private hospitals would have to (i) be given time to implement what would be significant changes to the way it collects and reports data; and (ii) be allowed to raise a charge for each procedure in order to cover the costs of implementing such a significant change. Since all members of the private healthcare market would ultimately benefit from this, it might be reasonable for such costs to be shared amongst all market participants.

BMI recognises the need to publish meaningful comparative information to patients via a dedicated platform and is happy to engage with the CC on how best to achieve this. BMI has actively encouraged and participated in initiatives to improve the quality of information given to patients; this will be a key mechanism to drive competition between hospitals to increase performance and outcomes.

(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?

35.15 It is clear that any measures taken to support and fund PHIN's (or its equivalent's) role in the private healthcare market should be borne by all market participants, including insurers, as all market participants will be beneficiaries of the improvements its role will bring to the market. PHIN provides an important service that directly benefits patients by assisting them to make informed decisions. This not only drives competition between hospitals to raise standards but it enhances patient confidence and satisfaction, which is crucial to stimulating growth in the PMI market.

(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?

35.16 BMI refers the CC to paragraphs 35 to 35.8 above.

REMEDY 8

A PRICE CONTROL

36. Remedy 8

The CC is not minded to consider further as a remedy “[a] price control would set the maximum prices that could be charged at hospitals which we consider have market power.”

- 36.1 A price control remedy would certainly be difficult for the reasons the CC has already identified.
- 36.2 BMI considers it odd however that the CC has dismissed price control so quickly yet proposed massive intervention in remedy 2 that would either have similar characteristics or place the role of economic regulation in the hands of the insurers – principally [X] – a dominant downstream intermediary.
- 36.3 In BMI’s view, price control could be a more just and fair approach with fewer adverse patient outcomes than Remedy 2(a).