Private Healthcare: Competition Commission Market Investigation

Response from Circle to Provisional Findings and Remedies Notice

September 2013

1. INTRODUCTORY COMMENTS

Circle welcomes the publication of the Competition Commission ("CC")'s Provisional Findings and Remedies Notice. Circle is delighted that the CC has recognised that there are structural problems in the private healthcare market, a number of which create barriers to entry for new players. Circle commends the CC for its clear action and broadly agrees as to the adverse effects on competition that result from these structural problems as identified in the Provisional Findings, and with the range of proposed remedies that the CC has set out in its Remedies Notice. Circle also endorses the CC's other provisional conclusions as to conduct features that give rise to AECs. However, Circle believes that there are still issues that remain unresolved and that should be addressed by the CC before its Final Report.

We have some specific comments on the provisional findings – specifically, in relation to PMI recognition, individual provider conduct, and consultant incentives – and on the Remedies Notice.

Circle looks forward to discussing these issues further with the CC during its Remedies Hearing on 7 October.

2. COMMENTS ON PROVISIONAL FINDINGS

General

Circle believes that the high barriers to entry and weak competitive constraints identified by the CC result in a lack of genuine competition in the private healthcare market. They are also mutually self-reinforcing: the high barriers to entry mean that it is very hard (if not impossible) to introduce new competitive constraints in the form of new operators into local markets, and the strong local market position of the biggest incumbents gives them sufficient local and national market power to reinforce the barriers to entry. For these reasons, Circle strongly supports the CC's Provisional Findings.

PMI recognition as a barrier to entry

Notwithstanding our support, Circle believes that the CC has erred in considering that PMI recognition is not in itself a barrier to entry, although some large hospital groups may have the ability to induce a PMI to refuse recognition of a new entrant locally (Provisional Findings, paragraph 6.72). Whilst Circle has not had the opportunity to review the CC's National Bargaining Analysis that was made available to the main hospital operators in its disclosure room earlier this month, we know that some of our larger competitors are (by virtue of their strong local market power and their national market power) able to bring pressure to bear on PMIs to refuse recognition to a potential new entrant. Indeed, it is Circle's own experience that this is the case, as occurred in Bath and as revealed by the CC in the Circle Bath case study (Provisional Findings, Appendix 6.1). However, the CC's conclusion conflates two issues: the market power of the major hospital operators and the market power of the PMIs.

Whilst PMI recognition may be withheld from a potential new entrant as a result of the wielding of market power by one or more major hospital operators, the CC has failed to recognise that in other situations it may be withheld by virtue of the market power of a PMI itself. The CC has acknowledged that the large PMIs (at least) have market power in the form of countervailing buyer power (Provisional Findings, paragraph 6.291) but has concluded that in bargaining with the major hospital groups, the PMIs' buyer power is insufficient to counteract the market power of the hospital groups. The CC has not considered what may result when a PMI negotiates with a hospital or hospital group that does not have market power – i.e. a potential new entrant. In this situation it is only the PMI that has bargaining power – and that power is significant indeed, because should the PMI choose to withhold recognition, the potential new entrant has no practical way of entering the market. For example, BUPA indicated that it would only grant recognition to Circle's new Reading facility if Circle agreed to pay any shortfall between the BUPA rates and the fees that consultants wished to charge. Circle had little choice but to accept this as it needed BUPA's recognition. As the CC has recognised, the proportion of PMI patients is much higher than the proportion of self-pay patients (see, for example, Provisional Findings Figure 2.5). An operator wishing to enter the market cannot rely on self-pay patients alone and therefore PMI recognition is a necessary condition to market entry.

A PMI may have a number of reasons to refuse recognition to a qualified potential new entrant which do not derive from pressure brought to bear on that PMI by a major hospital operator. Circle does not believe that a PMI should be forced to contract with a potential new entrant if, for example, that new entrant is offering prices that are demonstrably much higher than the PMI is willing to pay. However, if the new entrant is prepared to offer competitive pricing and meets objective quality thresholds, it should not be blocked from doing so by lack of recognition. Yet a PMI may refuse to recognise the new entrant for any reason. As the CC has recognised, PMIs have an increasingly broad range of tools at their disposal to affect a patient's choice of hospital, including restricted networks and open referrals. In effect, this situation penalises the new entrant for being small and not having sufficient national coverage and/or national market power to be of interest to the PMIs. So the situation will be self-perpetuating – new entry will not occur and the major hospital groups' market power will be reinforced by the strategic choice of the PMIs to withhold recognition from new operators.

Anti-competitive behaviour of hospital operators

Circle appreciates that the CC is not empowered under the Enterprise Act in the context of a market investigation to consider or make findings on possible breaches by market players of the provisions of Chapter 1 and/or Chapter 2 of the Competition Act 1998. However, Circle nonetheless considers that the Provisional Findings contain strong evidence of behaviour by at least one of its competitors that indicates an abuse of a dominant position. Specifically, by applying intense pressure on PMIs not to recognise Circle's new Bath facility, in order to reinforce its locally dominant position in the Bath market, we believe that BMI acted in breach of the prohibition on abuse of dominance contained in the 1998 Act. Circle further considers that there are indications that other hospital operators may also have committed breaches of the Competition Act, for example in the pressure they have brought to bear on consultants considering working with Circle. Circle is therefore surprised that the CC has made no reference whatsoever to Competition Act implications of the behaviour of the major hospital operators, either in the Provisional Findings or in the Remedies Notice.

Clinician incentives

Circle notes the CC's provisional conclusions in relation to clinician incentives of all types, including equity ownership. In particular, Circle notes the CC's view that equity ownership of private health facilities by consultants gives rise to harmful effects on competition, 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 (Provisional Findings, paragraph 8.134).

Circle welcomes the CC's recognition that equity ownership may help reduce barriers to entry (as it manifestly did in the Bath and Reading markets) and actively supports the government's employee ownership initiatives, especially in the healthcare industry. Circle believes, however, that the CC's provisional conclusions in respect of this remedy require further development and clarification. Specifically:

- What factors would be used to assess whether the reduction in barriers to entry is likely to be at least as beneficial to competition as any distortion is harmful?

- Who will be responsible for carrying out this assessment, and what point? Is this post-entry, when the reduction in barriers to entry is demonstrated by the entry or pre-entry in order to ascertain whether equity ownership is permissible?

- To which health professionals would this apply? Just to consultants, or to others such as GPs (most of whom are owners or co-owners of their practices)?

- Should small clinician-owned clinics be exempt?

In short, we believe that any attempt to prescribe when equity incentives reduce barriers to entry and when they do not raises numerous practical questions and has enormous consequences for providers and clinician-owned practices throughout the country. The CC needs to provide considerably more guidance as to how such a remedy would be applied.

3. COMMENTS ON REMEDIES NOTICE

The Remedies Notice seeks comments on a number of possible remedies to the AECs identified in the Provisional Findings. Circle's view on each is as follows:

Remedies which would directly address barriers to entry

In the Provisional Findings, the CC has come to a number of preliminary conclusions on barriers to entry, including that the following all constitute barriers to entry:

- There are significant capital costs in entering the market and there are large economies of scale relative to the size of local markets. These, combined with a static market, constitute the greatest barrier to entry (Provisional Findings, paragraph 6.79);

- Finding a site and obtaining planning permission for a new hospital could constitute a barrier to entry (Provisional Findings, paragraph 6.81);

- The need to persuade consultants to commit to a new hospital constitutes a barrier to entry (Provisional Findings, paragraph 6.83); and

- Some large hospital groups may have the ability to induce a PMI to refuse recognition of a new entrant (Provisional Findings, paragraph 6.84).

However, in the Remedies Notice the CC has explained that, whilst some of the remedy options may increase the prospect of entry and expansion, the CC could identify none which would directly address barriers to entry.

As the CC has recognised, Circle is one of the very few new entrants in recent times, and therefore feels well placed to comment on possible measures that would directly address these barriers to entry.

In relation to the first barrier identified by the CC, Circle's experience has been that the costs of entry are not insurmountable. It is possible to access sources of finance, provided that the potential new entrant can demonstrate a compelling business plan. This requires (1) a site: (2) consultants; and (3) a flow of patients, hence the critical importance of PMI recognition. In this way, the first barrier to entry can be redressed by removing the other three barriers to entry.

Circle has not found that identifying a site has proved to be a significant barrier to entry and indeed the case studies in the Provisional Findings do not highlight this as a particular problem. As Circle has illustrated in its previous submissions to the CC, planning permission has only been a barrier to entry when it has been used as a tool by competing providers of healthcare service

In other words, competitors have tried to prevent Circle's entry by using the planning process. Circle therefore suggests that the CC should consider a remedy which would prevent competitor representations (including from NHS organisations) being taken into account as part of the planning permission process.

Circle has also been able to secure consultant commitments and has not found this a significant barrier to entry, because it has been able to offer equity participation in the business to consultants (see below). The CC has recognised that this model may significantly reduce barriers to entry. Our experience has been that consultants are attracted to this model, but that many have been subject to pressures (both direct and indirect) by incumbent hospital operators to try to influence them not to work with us.

This is a related issue to the pressure that may be brought to bear by incumbents to induce a PMI to refuse recognition to new entrants. Both of these result from the local and national market power of incumbents that the CC has identified in the Provisional Findings and proposes to address in the Remedies Notice. However, we strongly believe that these tactics also constitute anti-competitive behaviour, as outlined above. As part of the CC's consideration of remedies, Circle therefore urges the CC to refer the behaviour of incumbents to the OFT for a full investigation under the Competition Act 1998, and in particular the actions taken by BMI to try to prevent Circle's entry into the local market in Bath.

Circle does not agree with the CC that PMI recognition is not in itself a barrier to entry (see above) and recommends that the CC considers mandatory PMI recognition of hospital operators. Circle proposes that recognition should be mandatory where a hospital operator can demonstrate that it would meet the "any qualified provider" requirements of the NHS – namely that it is prepared to provide healthcare services at the NHS rates and that it meets the CQC quality criteria. This would provide an objective basis for recognition and encourage new market entrants to invest capital, time, and resources to open new facilities. To ensure that this requirement is narrowly tailored, we would suggest that such mandatory recognition be limited to the time it takes for a new entrant to establish itself in a local market, which would probably be 3-5 years.

Finally, Circle strongly urges the CC to pay due attention to the market power of the PMIs in comparison with small hospital operators and new entrants (see above). Circle suggests that the CC should establish an independent monitor of the PMIs with an oversight function to ensure that the large PMIs do not abuse their market power in the future.

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

The CC is proposing that in local areas where it has identified competition concerns because several hospitals in that area are wholly or predominantly operated by one operator, that operator would be required to divest one or more hospitals and other appropriate assets.

Circle strongly supports the principle of divestiture as the most suitable remedy to redress the entrenched dominance of the national chains and HCA. We look forward to learning which facilities the CC has included in its list of "slightly fewer than 20" so that we may consider further how this remedy should be effected.

Turning to the CC's specific questions on this remedy:

Central London

- Circle fully supports the divestiture remedy as appropriate and proportionate to address the AEC.

- Given the number of hospitals that HCA currently owns and the PPUs that it operates (as well as the excessive profits that it has earned in 2007-12), Circle does not consider that divestiture of a single hospital by HCA would be sufficient to address the AEC. Subject to seeing further details on HCA's shares of supply, Circle does not consider that a single divestiture to a new entrant in the Central London market would create a sufficiently strong competitor to constrain HCA going forward.

- Circle does not consider that the remedy would be effective only if the entire package were divested to a single owner. Ownership by two or more purchasers would be more effective in addressing the AEC, as this would result in a greater increase in the number of market players and therefore more competition in the market.

- To ensure the effectiveness of the remedy, Circle considers that HCA should not be permitted to bid to run any more London PPUs or acquire any more healthcare facilities in London, for a period of at least 5 years from the date of divestment.

- To ensure that the divestiture remedy is effective, Circle proposes that consultants who currently practise at any facility to be divested should not be allowed to move their practice at that facility to any other facility operated by HCA for a period of 2 years post-divestment,.

- Circle considers that the sale should be effected as soon as reasonably practicable and sees no reason that the period to complete divesture should be greater than six months.

UK outside Central London

- Again, Circle fully supports the divestiture remedy as appropriate and proportionate to address the AEC.

- Circle agrees that proper attention should be given to anti-circumvention measures to ensure that consultants at the hospitals to be divested do not simply switch their practice to the divesting operators' remaining hospitals. As above in relation to HCA, Circle

proposes that consultants who currently practise at any facility to be divested should not be allowed to move their practice at that facility to any other facility operated by that same operator, for a period of 2 years post-divestment, to ensure that the divestiture remedy is effective.

- Circle proposes that the divestiture remedy should not just include full hospitals but also PPUs where they are operated by an operator who operates other healthcare facilities in the same local market and where there is a lack of sufficient local competition, using the same measures used by the CC in its analysis set out in the Provisional Findings.

- Again, Circle considers that the sale should be effected as soon as reasonably practicable and sees no reason that the period to complete divestiture should be greater than six months.

- Circle also suggests that the CC should give consideration to how this remedy will work effectively in the cases in which the operation of a facility is in separate hands from the ownership of the property itself ("OpCo" and "PropCo" structures). For example, if the remedy only requires the operator to dispose of the OpCo, what controls or requirements will be placed upon the owner of the PropCo in order to constrain that owner and ensure viability for the new entrant in that local market? It's vital that the CC ensure that the landlord cannot, for example, raise the rent so that the new entrant can no longer operate that facility on a sustainable basis.

Remedy 2: Preventing tying or bundling

The CC has proposed two alternative variants of this behavioural remedy to prevent BMI, HCA and Spire from using their market power in local areas when negotiating with PMIs.

The first variant would prevent any one of those operators from raising its prices nationally if a PMI changed its network policy such that patient volumes to the operator concerned were likely to fall. In other words, this controls the way in which the operators can negotiate with PMIs over prices, in one respect. The other variant would require BMI, HCA and Spire to offer and price their hospitals separately i.e. local pricing.

We do not believe the first variant (2a) is a complete remedy, in that it only addresses one aspect of the pricing negotiations between the incumbents and the PMIs, i.e. reductions in volume (which may result from delisting or from recognition of a new provider). Circle considers that whilst volume is clearly a key factor in pricing, there are various other issues that are considered during negotiations on a national scale.

Circle would instead strongly urge the CC to adopt the second variant (2b). PMIs have indicated they are prepared to negotiate local pricing and therefore there would not be any issues of practicability. Circle also considers that this remedy could come into effect fairly quickly, once the PMIs have taken the necessary steps to facilitate local negotiations. Because this is the only practical way to ensure that national market power does not factor in local negotiations, this remedy should extend not only to BMI, Spire and HCA, but to all multi-site owners in the country (including Circle, Ramsey, Nuffield etc.). This will put us all on an even footing and ensure that competition is truly local.

In the Remedies Notice, the CC implies that variant 2b may not be effective in Single hospital areas, because local pricing would mean that, in those areas, the PMIs would be negotiating with a monopoly provider. If any one of the Single hospitals were key to a PMI (e.g. because of the extent of local corporate PMI coverage), that hospital operator would have significant power in negotiations, not only over price but also over all aspects of negotiations, e.g. the operator might have the power to exert influence over PMI recognition

of new entrants. In such a situation, nothing would stop the provider from charging 2-3x more than prices prevailing in competitive local markets, which would drive up costs for both PMI members and self-pay patients.

As a consequence, the CC needs to consider a price control remedy (further representations on this are set out below). Circle would also suggest that the remedy of mandatory universal PMI recognition, which it has outlined above, would deal with the possibility that a local monopoly provider could try to exert its influence in other ways over the PMIs.

Remedy 3: Restrictions on expansion/Remedy 8: a price control

The CC has proposed that the AEC in Single or Duopoly areas be remedied by preventing an incumbent from expanding through arrangements with a PPU.

This is an appropriate remedy to ensure that incumbent providers with a significant local market share do not find other ways to grow their local influence. However, this remedy alone is insufficient to address the local market power of incumbents in Single or Duopoly areas, and therefore remedy 8 (a price control) is required in addition to combat this local market power. In the Remedies Notice the CC considered whether a price control would be an appropriate remedy in these areas but, on balance, decided against it. The reasons for this decision are unclear and Circle urges the CC to reconsider. We believe there are practical, effective means of using price regulation that are not unduly burdensome and do not require excessive independent regulation. In such areas, the incumbent provider(s) will be subject to no (or limited) restrictions on its market power absent this remedy, allowing it/them to raise prices – and, in Duopoly areas, raising the prospect of a local concerted practice.

Circle is aware that BUPA sets its starting price in negotiations with a new hospital by looking at a basket of prices in local markets in the vicinity of the hospital. The NHS also adjusts its tariff pricing based on local market factors. Circle therefore proposes that, in the case of Single or Duopoly areas, PMIs should be able to set a benchmark price based on the prices in adjoining local markets, and should then be permitted to negotiate with the Single or Duopoly operator(s) with pricing being no more than 20% above that benchmark price.

Remedy 4: Preventing hospital operators from offering any consultant incentives (subject to proviso on reduction in barriers to entry)

The CC has proposed that all consultant incentives should be prohibited, except where equity 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.

Circle has earlier raised questions about the precise scope and practical difficulties presented by this proposal. While Circle endorses the remedy in principle, it considers that it is important to distinguish clearly between the distortive effects of direct, short-term incentives (cash, in-kind benefits of value like medical secretaries and consulting rooms, etc.) which should be banned, and long-term incentives like equity, which also confer powerful market entry incentives through ownership and value creation. The Remedies Notice proposes that both types of scheme ("short-term" and "long-term") should be prohibited as it would be hard to draw a clear distinction between the two types of scheme. We disagree and urge the CC to reconsider the different impacts cash versus equity incentives have on consultant behaviour.

Remedies 5, 6 and 7: Information on fees and performance

Circle fully endorses the proposals by the CC in the Remedies Notice for the publication of consultant performance indicators, consultant fees and private hospital performance, and suggests that the CC should consider imposing a requirement that universal minimum standards are agreed by providers within 12 months.