



Private healthcare market investigation

Response to Provisional Findings

Bupa Health Funding

September 2013

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1. INTRODUCTION

- 1.1 Bupa Health Funding (“BHF”) welcomes the Provisional Findings (“PFs”) published by the Competition Commission (“CC”) on 28 August 2013.
- 1.2 BHF strongly supports the vast majority of the conclusions reached by the CC. We agree that substantial remedial action is required to address the significant and interconnected market failures in the provision of private healthcare (“PH”) by hospitals and consultants.
- 1.3 This response does not comment on every aspect of the PFs. Rather, we focus on providing additional evidence for a short list of key substantive points which we believe the CC could further consider in support of the theories of harm identified in the PFs.
- 1.4 Please note this submission contains commercially sensitive information and should not be published.

Structure of response

- 1.5 The response is structured as follows:
 - Part 2 provides an executive summary of the substantive points we ask the CC to consider further.
 - Part 3 covers consultant groups.
 - Part 4 covers hospital market power.
 - Part 5 covers unwarranted variation.
 - Part 6 covers information transparency.
 - Annex A contains [✂]

2. EXECUTIVE SUMMARY

- 2.1 BHF supports and agrees with the vast majority of the PFs. However, we ask the CC to further consider the following list of substantive issues. Each has a material impact on the CC's findings of Adverse Effects on Competition ("AEC") and will also impact the CC's design of remedies.

Consultants and consultant groups

- 2.2 BHF welcomes the CC's finding that some consultants and/or consultant groups may have market power. However, the CC's provisional finding that there is no AEC in relation to consultant groups does not follow from the evidence presented in the PFs. The CC's own evidence shows that:
- i. Patients are vulnerable and at risk of exploitation.
 - ii. Many anaesthetist groups ("AGs") have local market shares significantly in excess of 50% (i.e. levels that would typically strongly suggest dominance). The size of groups limits patient choice.
 - iii. In the overwhelming majority of instances studied by the CC prices are higher where AGs are present. The CC's conclusion that the evidence on price effects of AGs is 'mixed' does not follow from the evidence presented.
 - iv. Individual anaesthetists do not provide an effective constraint on groups. So, even if barriers to entry are low (a point we disagree with), AGs still have pricing power.
- 2.3 There is, therefore, significant evidence that AGs restrict competition and choice and can harm consumers. There is no evidence that the alleged benefits of AGs outweigh this harm. There is no evaluation in the PFs of whether the alleged benefits of AGs are real (i.e. more than just claims), specific to forming groups, or actually translate into improved outcomes for patients.
- 2.4 BHF, therefore, asks the CC to continue investigating this important theory of harm. BHF would welcome more transparency from the CC on its analysis to date; in the face of the risks to consumers presented by AGs, 'incomplete data' is not a sufficient justification for a finding of no AEC.

2.5[✕]

2.6[✕]

Hospital market power

- 2.7 BHF agrees with the four AECs relating to hospitals: weak competition at a local level; high barriers to entry; the distortive effects of clinician incentive schemes; and, inadequate provision of information on quality. The need for significant remedial action is clear. There are, however, four issues in particular that BHF asks the CC to further consider.
- 2.8 First, the CC's current approach of considering only 17 specialisms, with 16 considered as a group, will understate the market power of certain hospitals at the local level. This approach will

overstate the effectiveness of competition between hospitals. A specialism-level analysis should be conducted (also covering a broader range of specialisms). This would show an increased number of 'hospitals of concerns'. Examining provision at a specialism-level will be important when the CC is determining effective remedies.

- 2.9 Second, BHF believes that the scale of a hospital group confers market power (incremental to that derived from 'must have' hospitals). It is much easier to negotiate a fair price with a single hospital than when that same hospital is part of a large group. The insurer can focus all of its energy on one negotiation, with customer and reputational damage more likely to be contained to that one local area. This compares favourably with the insurer having to fight disputes in, and so spreading its resources thinly across, several markets simultaneously with a far larger number of customers (in particular large corporates), consultants and intermediaries negatively affected. Similarly, it is easier to negotiate a fair price with two groups of 30 hospitals than one group of 60. The implication is that the scale effect of the largest hospital groups must be reduced if the CC is to rebalance bargaining power between insurers (particularly smaller ones) and these groups. On this basis, the CC must consider more far-reaching divestment remedies to reduce the scale of the main groups. For example, if a large group divests a 'must have' hospital, and this hospital stands alone, then (a) not only is the scale and strength of the large group reduced (improving insurers' bargaining position) but (b) insurers also have an improved chance of getting a fair price from the standalone 'must have' facility.
- 2.10 Third, the CC does not find Ramsay and Nuffield to have market power. We disagree with this conclusion. It may be true that Ramsay and Nuffield do not have *as much power* as Hospital Corporation of America ("HCA"), BMI and Spire. However, this does not mean they do not themselves have market power. Both Ramsay and Nuffield own a significant number of 'hospitals of concern' identified by the CC – for example, over [X].
- 2.11 Fourth, the PFs do not set out a clear position on vertical integration between hospitals and primary care. A strategy of acquiring primary care providers, such as GP practices, is increasingly being employed by hospital operators. Significant concerns arise for patient choice and competition when a hospital operator acquires a GP practice or clinic. In effect, the arrangement can have the same impact as a consultant incentive in influencing referral patterns. The NHS recognises these concerns and has safeguards in place e.g. specifically requiring the competition authority in the NHS to assess the impacts of a merger on GPs' independence. Private healthcare does not have these safeguards. Therefore, BHF would welcome further clarification from the CC on this increasingly important feature of the private healthcare market, particularly in central London.

Unwarranted variation

- 2.12 BHF asks the CC to reconsider two statements in the PFs related to unwarranted variation that are not based on sufficient evidence.
- 2.13 First, the CC says that the NHS does not present a relevant benchmark to private practice because the NHS has a tendency to under-treat. We are surprised that the CC has taken this position on the NHS and would welcome seeing the evidence for this systematic under-treatment. Even if under-treatment were a feature of the NHS, this would not discount other case studies submitted to the CC that show unwarranted variation relative to the benchmarks of other private doctors or of evidence-based medical guidelines (i.e. unrelated to whether or not the NHS is a relevant benchmark).
- 2.14 Second, the CC says that instances of over-treatment of surgical procedures "*are likely to be few and far between*" due to 'ethical and regulatory constraints' on doctors. This is a very strong

position for the CC to take. It reduces surgical ‘over-treatment’ to a trivial issue and contradicts a significant body of international academic research and experience. Moreover, the PFs do not present the evidence on which the CC reaches this position. BHF has strong concerns that this precedent from the CC will create significant challenges for commissioners of care to engage healthcare providers in analysing and addressing unwarranted variation. More importantly, if the CC is incorrect, patients will be put at risk. BHF therefore asks the CC to reconsider its position, or at least set out further evidence on how it has reached its view.

Information transparency

- 2.15 BHF agrees that there is a significant lack of information provided to patients by hospitals and consultants. However, the CC must consider three further issues relating to information.
- 2.16 First, the Information Availability section of the PFs focusses almost exclusively on the provision of information to patients. The CC must also consider the provision of information to those who commission care on consumers’ behalf (i.e. insurers). Currently the flow of information to insurers is poor and healthcare providers place constraints on its use. Patients will benefit both clinically and financially if better information is provided to their insurers by hospitals and consultants. This directly impacts remedy design.
- 2.17 Second, there is a significant lack of standardisation in coding by PH providers both on impairment codes and activity codes. This lack of common architecture undermines insurers’ ability to benchmark providers, thereby limiting competition. It makes it significantly harder to identify and address unwarranted variation. It also increases transaction costs. The CC itself experienced this first-hand in the challenges of comparing hospital prices. The lack of standardisation is a structural feature of the market creating an AEC. It requires further examination by the CC.
- 2.18 Third, the CC notes the recent NHS England initiative to publish consultant-level performance data in ten specialisms. However, it is incorrect to believe that this information will solve the lack of information on consultant quality that today undermines patient decision making. The NHS England initiative is very limited in terms of the procedures and consultants covered and the quality measures published. The key concern is that the information published will not fundamentally change or improve patient decision making. So while this initiative is a small step forward, the CC should not count on it solving the AEC relating to information on consultant quality.
- 2.19 Finally, BHF acknowledges the comments made by the CC in the PFs about BHF improving its communication with customers. BHF will continue to work hard to treat customers fairly through delivering clear and relevant information to our policyholders. The Financial Conduct Authority (“FCA”) provides a safeguard and we engage actively with the FCA to continue to fulfil our responsibilities and maintain our high standards.

3. CONSULTANTS AND CONSULTANT GROUPS

- 3.1 BHF welcomes the CC's provisional findings that:
- i. Factors suggest that some consultants and consultant groups may have market power.
 - ii. There is no evidence that insurers' actions have reduced the supply or quality of consultants.
 - iii. There is a lack of information transparency on consultant prices or quality.
 - iv. Consultant incentives can distort competition and lead to unnecessary tests and consultations.
- 3.2 However, the CC's finding of no AEC in relation to anaesthetist groups simply does not follow from the evidence that has been presented to, and relied upon by, the CC.

MARKET DEFINITION FOR ANAESTHETISTS

- 3.3 The PFs explain "*In relation to consultant services, we conclude that the market is local. However, for the purposes of our analysis, it is not necessary to define these markets, as this will not have any impact on our provisional findings*"¹. However, as explained below, there appear to be flaws in the reasoning that no AEC is caused by consultant groups, meaning that market definition is still a relevant factor for the CC. The CC must reconsider its decision not to define the relevant market for consultants, and anaesthetists in particular.
- 3.4 As previously explained by BHF, the geographic market for anaesthetists is very narrow. It is likely confined to the choices as to anaesthetists available to a patient within a hospital in which that patient receives treatment. Most patients rely on their consultant to choose the anaesthetist². This means that the patient often only meets the anaesthetist, and becomes aware of the anaesthetist's fees, shortly before surgery. At this point there is little opportunity to switch to anaesthetists outside the hospital without significant costs (e.g. rescheduling the surgery or potentially changing the treating consultant). The patient's choices are therefore significantly restricted. This indicates a very narrow geographic market.

¹ PFs, paragraph 5.57.

² The PFs note: "*The surgical consultant will not generally consider cost to be a factor in the selection of the anaesthetist and, together with historical preferences of the surgical consultant, the patient's choice of available anaesthetists in an area may therefore be limited*" (paragraph 7.3(c)).

CONSULTANT GROUPS

- 3.5 BHF welcomes the CC's conclusion that factors suggest "*some consultant groups may have market power*"³.
- 3.6 We are however surprised that the CC has provisionally concluded that there is no evidence of an AEC in relation to anaesthetist groups ("AGs")⁴. There appears to be no proper basis for this conclusion.
- 3.7 In particular, the CC appears to have ignored its own evidence that shows quite clearly that:
- i. Anaesthetist groups often have **very high market shares**:
 - The 11 AGs the CC investigated each appear to have over 50% of anaesthetic activity in their main hospital⁵. Indeed, in the CC's six detailed case studies: two AGs had shares of all anaesthetic treatments (by volume) of *over 80%*; two AGs had shares *over 70%*; and two AGs had shares *over 50%*.
 - Similar evidence is found in (a) an AAGBI survey showed that 77% of the 30 AGs surveyed earned *over 50%* of the total anaesthetic revenues available in their base hospital; with **43% earning over 90%** of the revenues⁶; and, (b) BHF's submitted evidence based on observed claims activity⁷.
 - Undertakings with shares of this size would typically be presumed dominant⁸.
 - ii. The formation of anaesthetists into groups has led to significantly higher prices for consumers in all areas studied by the CC. The CC's preferred indicator – a comparison of prices pre and post the formation of a group – showed the formation of a group increased prices in **13 out of 15** treatments studied.
 - iii. The prices charged by AGs are higher, on average, than those charged by individual (non-group) anaesthetists. This result is found repeatedly across the CC's measures⁹.
- 3.8 The CC also appears to have placed little weight on: BHF's own evidence that both the rate and the frequency of shortfalls are much higher where AGs account for 75% to 100% of activity in hospitals; case studies by AXA showing increases in prices due to AGs; and, analysis by Prudential showing higher prices from AGs. It also does not appear to have had regard to the

³ PFs, paragraph 7.3.

⁴ PFs, paragraph 7.82.

⁵ The CC explains that, for the 11 AGs the CC investigated, non-group anaesthetists accounted for "*between 50 and 10 per cent of anaesthetist services at the main hospitals*" (paragraph A7(1)-14), which suggests in each case that the AGs accounted for between 50% and 90%.

⁶ See AAGBI Submission to the CC, Figure 9 on p9. This shows answers to the question "*What proportion of the total anaesthetic fees earned in your base hospital is earned by your group?*"

⁷ BHF Original Issues Statement Response ("OISR"), Table 29.

⁸ The OFT Guidelines on "Abuse of a dominant position" notes for example: "*The European Court has stated that dominance can be presumed in the absence of evidence to the contrary if an undertaking has a market share persistently above 50 per cent*" (paragraph 4.18).

⁹ We noted also that AGs have high rates of charging shortfalls to patients. The AAGBI survey for example showed that the average percentage of patients asked by an AG to pay a top-up fee was 43%, with nine AGs asking over 60% of insured patients to pay a top up.

AAGBI's survey evidence that nearly a third of AGs surveyed considered that competition between anaesthetists was not very effective in their local markets¹⁰.

- 3.9 We therefore do not believe that the evidence cited by the CC supports a finding that there is 'no evidence' of an AEC in relation to AGs.
- 3.10 In rejecting an AEC in anaesthetists' services the CC appears to have given considerable weight to its belief that barriers to entry are low. The CC's approach has been to note the limited barriers to individual anaesthetists entering the market and winning business. However, as the CC's Market Investigation Guidelines make clear, the relevant question is not whether barriers to entry are low, but whether new entrants - in this case individual anaesthetists - are able to provide an effective competitive constraint. But, as the CC's own evidence suggests, individual consultants do not constrain prices significantly. Notably, the prices charged by AGs are, on average, higher than those charged by individual anaesthetists. New anaesthetists also have strong incentives to join the group and get higher prices; neutralising the effect of the entry. We explain further below the barriers to entry and expansion which have not been examined by the CC and which indicate individual anaesthetists place little constraint on incumbent AGs.
- 3.11 This is a very important issue for consumers. The formation of anaesthetists into groups with market shares of 50% and above severely limits consumer choice and, the evidence shows, is likely to lead to higher prices. This issue is even more significant given the CC's own acknowledgement that customers are in a very vulnerable position and do not have the information or expertise to be able to make effective choices. Higher prices show that exploitation of market power is a real factor.
- 3.12 We would therefore ask the CC to review the evidence and, if necessary, collect more information to test this important theory of harm. BHF is very willing to assist the CC in any way it can in collecting the necessary data. The current decision to find no AEC is very likely to give impetus to further groups forming in anaesthetics and other specialisms which will increase the number of patients at risk.

The CC's approach

- 3.13 The CC's theory of harm is that groups of anaesthetists (and consultants more generally) may be able to exercise market power over consumers where they have a relatively high share of supply in a local area. This harm could take the form of higher prices, reduced choice, inferior quality and inefficiency.
- 3.14 The CC's approach appears to have five steps:
- i. It identifies whether factors suggest groups of consultants have market power.
 - ii. It assesses barriers to entry for individual anaesthetists.
 - iii. It tests whether there is any evidence of market power being exploited.
 - iv. It explains possible benefits that may arise from groups forming.

¹⁰ If you exclude respondents who said "Don't know", **50%** of the AGs surveyed replied '*Not very effectively*' or '*Not very effectively at all*' to the question "*How effectively do you think competition between anaesthetists operates in the private healthcare market in your locality?*" This is clearly a highly concerning result.

- v. It then makes the inference that, as it (provisionally) finds no concerns about AGs and that there were more limited complaints about groups in other specialisms, then there are unlikely to be problems (or need for any investigation) of consultant groups in other specialisms.

Factors suggest market power

3.15 The CC identifies a number of factors that indicated that groups of consultants may have local market power. These include:

- i. High local market concentration.
- ii. Low price elasticity of demand¹¹.
- iii. High customer switching costs.
- iv. Vulnerable consumers¹².
- v. Limited information and transparency available to patients about price or quality.

3.16 We agree with this analysis. As the CC notes, customers are vulnerable to being exploited. They have poor information and rely almost entirely upon the consultant to make their choices for them. The price elasticity of demand is very low which implies that customers are entirely reliant on competition between anaesthetists to secure competitive prices. This alone suggests that the CC should be very cautious before it reaches a conclusion that competition is working effectively in the local market for consultant services.

Analysis of entry barriers

3.17 The CC reaches a provisional view that barriers are low for new individual anaesthetists because: (i) no AG had an exclusive agreement with the hospital in which it operates; (ii) there are individual (non-group) anaesthetists active in the hospitals of the AGs (despite such anaesthetists accounting for as little as 10% of anaesthetist services in some hospitals); and (iii) there are few barriers to a new anaesthetists joining the AGs if he or she wishes.

3.18 However, this analysis is insufficient. As noted above, the critical question is not whether barriers to entry are low, but whether individual anaesthetists – who are often fringe players – provide an effective competitive constraint.

3.19 The CC's own evidence questions whether this is the case. It shows, for example, that AGs charge over 5% more on average than individual anaesthetists. This is consistent with them providing a limited constraint¹³.

¹¹ The patient must have the treatment. The treating consultant who chooses the anaesthetist is not price sensitive.

¹² Patients are in a vulnerable position from a health and emotional perspective. They face significant information asymmetries. Self-pay patients also do not have any protection from the (alleged) countervailing buyer power insurers have over consultants.

¹³ There is no evidence that there is a quality difference between group and non-group anaesthetists that would justify the differential.

- 3.20 A number of factors support the suggestion that individual anaesthetists can only act as a limited constraint:
- i. Entrenched consultant to anaesthetist referral patterns will mean that the only way an individual anaesthetist can expand volume is if he or she can convince treating consultants to refer volume away from their 'usual' anaesthetist. However, if consultants have entrenched relationships with group members then the individual anaesthetists cannot rapidly increase volume.
 - ii. As the CC has found, there is lack of comparable information on the price and quality of anaesthetists. This means that new anaesthetists may struggle to enter and become established in a local market. This lack of information also makes it difficult for anaesthetists to differentiate themselves from others and so to increase referrals.
 - iii. Individual anaesthetists can simply follow the AG's pricing, as the lack of price sensitivity from consultants means individual anaesthetists gain little additional patient traffic from undercutting the AG.
 - iv. There are limited incentives to compete against the members of a large AG because members of that AG are often colleagues, even superiors, at the local NHS Trust.
 - v. The anaesthetist could also be persuaded to join an AG rather than undercut it¹⁴. Increasing group membership will not constrain that AG – instead, the group becomes larger and more stable.
- 3.21 There are, therefore, a number of reasons to suggest that independent anaesthetists have little incentive to undercut the dominant AG in their hospital. This means that they offer little effective competitive constraint.

Evidence the market power is being exploited

- 3.22 To test whether there is any evidence of AG market power being exploited the CC focuses on whether the price of anaesthetists' services is higher in local areas where groups account for a high proportion of treatments¹⁵.
- 3.23 The CC examines the impacts of AGs on price in a number of ways, but its preferred basis is to compare the price of anaesthetists' services in locations pre- and post the formation of a group. We agree that this "event study" approach is a suitable means of examining whether the formation of groups of consultants are likely to lead to higher (or lower) prices.
- 3.24 The CC concludes that *"the evidence available to us does not show that anaesthetist groups have an effect on prices for anaesthetist consultant services. In particular, although the national and regional analyses generally suggest a price effect of anaesthetists groups, we have placed less weight on these analyses as they do not control for geographical differences. In relation to the individual case studies, the evidence of a price effect of anaesthetist groups was mixed."*

¹⁴ The AAGBI notes that *"the way that a newly appointed consultant will enter private practice will depend upon local circumstances. If there is a local AG, they will most likely seek to become a member of the AG, and indeed may be invited to join the AG as an automatic consequence of their taking up a consultant post"* (see <http://www.aagbi.org/sites/default/files/AAGBI%20FINAL%20response%20to%20OFT.pdf>, accessed June 2012).

¹⁵ We note that the impact on price represents only one potential customer detriment. The formation of groups can also severely limit customer choice and it can lead to less competitive pressure on anaesthetists to be efficient or to deliver quality.

- 3.25 We do not understand how the CC, acting reasonably, can reach this conclusion when its own evidence shows:
- i. At the local level, the formation of groups led to a price increase in 13 out of 15 treatments. So the CC's preferred indicator gives strong support for a price impact from groups.
 - ii. Price rises appear significant. At national level, average prices are around 7% higher for AGs than for independent anaesthetists¹⁶.
 - iii. 9 of the 10 AGs studied show prices higher than non-group members in a similar region.
- 3.26 Table 1 summarises the CC's analysis as presented in the PFs. Instances where AGs have higher prices are highlighted in green (marked also with "H"). Instances when the AG price is lower are highlighted in red (marked "L"), and there are blank cells where the CC says it did not have enough data. The table is overwhelmingly shaded green – evidence prices are higher when an AG is present.
- 3.27 The only outlier appears to be Group 3 studied by the CC in case study D. This AG has lower prices despite its size. However, this single outlier does not invalidate the broader trend that AGs are associated with higher prices. Nor does the absence of sufficient data in some cases provide a basis for the CC to reach a positive conclusion that there is no effect on prices.
- 3.28 The CC has not presented the detail of these price effects. For example, the CC does not report the annual price changes, but instead appears to present an average price change for the whole period post the formation of the group (relative to the control group). The CC also does not present the average price change for each treatment, but instead provides a weighted average across treatments. The CC also does not detail the sample size, or whether these price changes are statistically significant. Without such information - and BHF would welcome greater transparency in the presentation of these results - it is difficult to comment further on the CC's analysis. However, at face value, with 13 out of 15 observations showing that the formation of a group led to a price increase, it is not reasonable for the CC to conclude that the evidence is "*mixed*".
- 3.29 The context is also important here. With very high market shares, we would suggest that the CC should be very cautious in concluding that there is no evidence that market power is being exploited. The evidence that the formation of AGs is overwhelmingly correlated with significant price increases suggests at the very least that this issue warrants more detailed investigation.

¹⁶ This will be conservative because some of the 'individual anaesthetists' (the control group) will themselves be part of groups not in the 45 studied by the CC or will be able to charge more because they operate in highly concentrated areas dominated by groups (and can 'follow' these prices).

Table 1: Summary of the CC’s analysis on AGs in Provisional Findings

| National | | AG prices “around 7 per cent” higher | | | | | | |
|---|---|--------------------------------------|-----|---|---|---|---|--|
| Regional | | Treatments | | | | | | Weighted average |
| | | 1 | 2 | 3 | 4 | 5 | 6 | |
| Region 1 | Average annual fees | H | H | H | H | H | H | Higher |
| | Group 1 | H | H | H | H | H | H | 18% higher |
| | Group 2 | H | H | H | H | H | H | 9% higher |
| | Group 3 | H | H | H | L | L | L | 9% lower |
| Region 2 | Average annual fees | H | H | H | H | H | . | Higher |
| | Group 4 | H | H | H | H | H | L | 13% higher |
| | Group 5 | H | H | H | H | H | H | 10% higher |
| | Group 6 | H | H | L | L | . | . | 2% higher |
| | Group 7 | H | H | H | H | H | L | 12% higher |
| | Group 8 | H | H | H | H | L | L | 4% higher |
| | Group 9 | H | H | H | H | H | H | 12% higher |
| | Group 10 | H | H | L | L | . | . | 4% higher |
| Case studies | | | | | | | | |
| A Group 1 Over 80% share by volume | Average AG price vs. regional average | H | H | H | H | H | H | Higher for period 2006 to 2012 |
| | Increase due to group forming | H | H | H | H | H | L | Higher in 5 of 6 |
| | AG compared to another hospital where smaller AG operated | H | H | H | . | . | . | Higher in all years |
| B Group 6 Over 60% share by volume | Average AG price vs. regional average | H | H | . | . | . | . | Higher in 2 |
| | Increase due to group forming | H | H | H | H | L | . | Higher in 4 out of 5 |
| C Group 4 Over 50% share by volume | Average AG price vs. regional average | H | H | . | . | . | . | Higher in 2, and in 3 rd treatment in 2010/12 |
| | Increase due to group forming | H | H | H | H | . | . | Higher in 4 of 4 |
| D Group 3 Over 80% by volume | Average AG price vs. regional average | L | L | L | L | . | . | Lower in 4 |
| | AG compared to another hospital where smaller AG operated | = | = | . | . | . | . | Fees similar |
| E Group 5 Over 70% by volume | Average AG price vs. regional average | H | H | H | H | = | = | Higher in 4 (other 2 higher in initial period) |
| | AG compared to non-group members in same hospital | H | H | L | . | . | . | Higher in 2 but gap shrinking |
| | AG compared to another hospital where smaller AG operated | H | H | . | . | . | . | Higher for only part of period. |
| F Group 6 Over 70% by volume | Average AG price vs. regional average | H | H | H | L | . | . | Higher in 3, with 4 th higher by 2012 |
| | AG compared to non-group members in same hospital | = | L/H | . | . | . | . | Fees similar, with one low in initial period and then high |

Source: PFs, Appendix 7.1, pages A7(1)-7 to A7(1)-11.
 Notes: “H” = Price of AG higher; “L” = Price of AG lower.

3.30 The CC appears to shy away from what appears to be clear evidence of a link between AGs and high prices because of:

- i. Incomplete data. This is surprising because the CC in fact appears to have a substantial amount of data covering 6 treatments, spanning groups in several regions and across 8

years. However, we also believe that the data is available from the AGs and would urge the CC to exercise its powers to obtain more detailed data if this is required¹⁷. An absence of data is not a satisfactory basis for conclusion that there is no AEC.

- ii. **Omitted factors.** The CC says that the prices vary significantly across the country but that its analysis does not control for some factors that may impact prices¹⁸. The CC does not say what these omitted factors are. We assume one of these is cost factors that vary across the country and so may impact price (e.g. costs of practice being higher in a city than in a rural area). However, BHF believes the CC's concern about omitted factors is overstated. In statistical testing, omitted variable bias arises when both (i) the omitted factor, here 'local costs', determines the dependent variable (anaesthetics prices), and (ii) the omitted factor is correlated with one of the independent variables, here 'the presence of a group'. If local costs and 'presence of a group' are correlated (i.e. groups are more likely in high cost areas), then omitting local costs from the equation to determine prices will overstate the importance of 'the presence of a group' in determining price. The coefficient on 'the presence of a group' will include the effects of both the presence of a group and local costs – it will be overstated. However, we do not believe there is any evidence, or reasonable presumption, that the presence of groups and local costs are correlated. AGs appear all over the country. They do not appear to be concentrated only in higher cost areas. If the presence of a group is uncorrelated with the CC's omitted factor(s), then the relationship between presence of a group and higher prices is real in spite of the omitted factors. We ask the CC to reconsider its thinking on this.

Benefits from anaesthetist groups

3.31 The CC notes some of the benefits that the AAGBI and surveyed AGs claim arise due to groups. However, there is no interrogation of whether these alleged benefits are:

- i. Real rather than simply claims;
- ii. Specific to forming a group i.e. could not have been achieved without the restriction in choice and competition; and
- iii. Flow through to the patient. Indeed, the higher prices from AGs suggest that patients are not sharing in any of the cost efficiencies that may arise from groups (e.g. shared secretarial costs). This is especially likely to be the case as there is no mechanism through which anaesthetists are incentivised to compete on price or quality grounds for patients.

3.32 In the face of market power (dominance) and evidence of abuse (unjustified higher prices), the alleged benefits need be justified and evidenced to a far higher standard than they have been to date to offset concerns about consumer detriment.

Other consultant groups

3.33 Having provisionally concluded that there is no AEC from AGs, the CC then decided not to investigate groups in other specialisms. [✗]

¹⁷ For example we note that only 45 of the 100 AGs surveyed by the CC provided information.

¹⁸ The CC says "any differences between the average fees set by members of the group(s) and non-members of groups in the national and regional analyses, could be explained by factors other than the presence of the group" (PFs, paragraph 13, p A7(1)-7).

- 3.34 [X]
- 3.35 X]
- 3.36 [X]

Summary – what BHF asks the CC to do

3.37 The evidence in front of the CC suggests: many AGs have dominant market shares; AGs do increase prices; and the alleged benefits of AGs are unsubstantiated. Barriers to entry and expansion exist and, even if they were low, this does not imply individual anaesthetists constrain group pricing. The issue of consultant groups is not limited to anaesthetists: there is also evidence of an AEC in [X] due to a plethora of groups and collective negotiation by [X]. *Ex post* competition law does not allow for effective solutions to such AECs. Therefore, patients are vulnerable and at risk of exploitation.

3.38 On this basis, BHF asks the CC to:

- a. Reconsider its provisional finding of no AEC in anaesthetist groups. This is not supported by the evidence or analysis to date.
- b. Give more transparency on the data used in the anaesthetist group analysis. This may involve allowing our economic advisors to examine the data in a data room.
- c. Pursue further data from AGs if concerns about the sufficiency of existing data are the reason the CC has dropped this important theory of harm (as is suggested by the PFs).
- d. Reconsider the CC's concerns about omitted factors weakening the link between AGs and high prices. These concerns appear overstated.
- e. Conduct a more detailed investigation about whether non-group anaesthetists are an effective competitive constraint. The evidence suggests they are not and there is no mechanism of competition through which this could happen.
- f. Interrogate the alleged benefits of AGs. These would need to be proved to a high standard to outweigh the evidence of abuse of dominance.
- g. Investigate consultant groups in [X]. These groups are clearly leading to an AEC in this relevant market.

4 HOSPITAL MARKET POWER

- 4.1 BHF welcomes the CC's detailed analysis of hospital market power. BHF agrees with the provisional findings that:
- i. A very large number of hospitals in the UK face insufficient competitive constraints at a local level.
 - ii. Hospital Corporation of America dominates the central London market, in particular in key specialisms, and constraints on HCA from inside and outside London are weak.
 - iii. Most private hospitals are also protected by high barriers to entry – most notably high capital costs and economies of scale. Entry of full-service line hospitals is very rare.
 - iv. Large hospital groups are in a position to leverage the strength of their 'must have' hospitals into national prices negotiations with insurers.
 - v. Insurer recognition is not itself a barrier to entry. However, some hospital groups are in such a strong position that they can induce an insurer not to recognise a rival hospital.
 - vi. There is a causal relationship between higher concentration at a local level and higher prices for self-pay patients.
 - vii. No insurer has sufficient buyer power to offset the strength of the main hospital groups. The small insurers in particular are weak – some paying similar amounts to self-pay patients.
 - viii. HCA and BMI have systematically higher prices than other hospital groups.
 - ix. Private hospitals (including HCA, BMI and Spire) have been earning excessive economic profits to the detriment of patients. Profits are also increasing rapidly.
 - x. Hospitals are not providing sufficient information on quality to patients or insurers.
 - xi. Some hospitals have used clinician incentives schemes to distort referrals against the best interests of patients or competition.
- 4.2 The CC identifies four AECs in relation to hospitals: weak competition at a local level; high barriers to entry; distortive clinician incentives; and, inadequate provision of information. The need for significant remedies is clear.
- 4.3 BHF, however, believes the evidence suggests the CC should strengthen its position on the following:
- i. The lack of effective competition facing many hospitals is even more pronounced at the specialism-level. This means the CC currently understates the market power of many hospitals at a local level.
 - ii. The *incremental* impact that the scale of a hospital group has on its market power. Market power is not derived solely from hospitals facing weak competition at a local level. The scale dimension of market power is itself an AEC.

- iii. The market power of Ramsay and Nuffield.
- iv. Hospital operators acquiring primary care providers (such as GP practices) is an increasing trend that raises risk to competition and choice for patients. Safeguards must be put in place.

4.4 We also note two points of detail about ‘one in, all in’ negotiation and the CC’s insured prices analysis.

SPECIALISM-LEVEL ANALYSIS

4.5 The CC provisionally found that each specialism is a separate product market. In the competitive assessment, however, the CC then looks at 16 main specialisms in aggregate with oncology considered separately (so 17 specialisms in all)¹⁹. BHF notes that the CC’s current approach will overstate the degree of competition between hospitals and will therefore understate the market power of many hospitals.

4.6 BHF previously raised the following points to the CC²⁰:

- i. A hospital may ‘offer’ a specialism, but at such a small scale that it is not an effective constraint on other hospitals or a credible choice for insurers. BHF illustrated this in relation to PPUs in Appendix A of its AIS response. Many PPUs may appear to ‘offer’ the 16 specialisms, where in fact they only undertake meaningful levels of work in a small subset of the 16 (i.e. they focus on a niche of specialisms). Barriers to expansion (e.g. the challenges of finding relevant consultants) mean that a hospital with only a very small presence in a specialism will struggle to ‘scale up’ to a meaningful size rapidly, even if it offers that specialism already. Therefore, the CC should be cautious in assuming that simply because over 80% of the hospitals it investigated offer the 16 specialisms, this means that these hospitals are all in a similar competitor set across the 16 specialisms and can constrain each other effectively in relation to each of the single specialisms within this subset.
- ii. Aggregating the 16 specialisms will hide pockets of market power within certain specialisms.
- iii. There are specialisms outside of the top 17 that are important and confer market power to the limited number of hospitals that offer them. As noted in the BHF AIS Response, hospitals that offer “less common” specialisms often have a powerful bargaining chip. BHF recommended that the CC should also investigate hospital market power in the following specialisms: Neurosurgery, Haematology, Cardiothoracic Surgery, Geriatric Medicine, Endocrinology, and Paediatrics. For example, as shown in Appendix A of the AIS response, BHF inpatient spend on Cardiothoracic Surgery is higher in absolute terms than BHF’s spend on each of 10 of the CC’s 16 “common” specialisms. Therefore, BHF may have little choice but to maintain a material amount of spend at a hospital providing Cardiothoracic Surgery even if there are other hospitals nearby offering some of the more common specialisms.

¹⁹ The CC says it is reasonable to look at the 16 specialisms together because the 16 specialisms are offered by 80% or more of the 215 general private hospitals and PPUs the CC considers and hospitals are able to supply-side substitute relatively easily within specialisms already offered.

²⁰ See BHF’s Annotated Issues Statement (“AIS”) Response.

- 4.7 At paragraph 6.115(c) the CC mentions (some) of BHF's concerns. However, beyond this mention, the CC does not appear to strengthen its local markets competitive assessment by considering hospitals at the more granular specialism-level. Therefore, the CC should recognise in its Final Report that its approach may overstate the degree of competition between hospitals at a local level. This will understate the number and strength of 'hospitals of concern' in the UK and the resulting strength of their relevant hospital groups.

THE IMPACT OF “SCALE” ON HOSPITAL GROUP MARKET POWER

- 4.8 The CC appears to believe that the market power of a hospital group stems only from the hospitals it owns that face weak competition at a local level, and not from the overall scale of the group. At paragraph 6.247(e), for example, the CC says: *“our view is that having hospitals facing low levels of competition in one or more local areas (i.e. hospitals which are less substitutable for the PMIs at the local level on average) strengthens the position of a hospital operator in negotiations with PMIs and is likely to lead ... to higher prices to PMIs at a national level. Our view is also that the overall size of hospital operators is unlikely to have an impact on insured prices in addition to the impact of insufficient competitive constraints at the local level on average”*.
- 4.9 BHF disagrees with the view that the overall size of a hospital group does not itself impact bargaining position. Hospital group scale has its own incremental impact on market power.
- 4.10 First, we note that the term ‘scale’ has several dimensions. It can incorporate (a) the total number of hospitals in the portfolio, (b) the overall financial scale of the hospital group, and (c) the number of ‘must have’ hospitals in the portfolio. Each dimension impacts the market power of the hospital group.
- 4.11 The CC appears to accept that a hospital group that is larger because it controls a number of ‘must have’ hospitals will be stronger:
- i. *“In our view, a PMI has weaker outside options when it is negotiating with a hospital operator that has **more** hospitals facing weak competitive constraints in locations that are important to the PMI (and its customers)”* (emphasis added)²¹.
 - ii. *“...the **more** hospitals that a hospital operator owns in areas where there are limited competitive alternatives, and where there were significant number of PMI customers, the stronger its bargaining position would be”* (emphasis added)²².
- 4.12 BHF agrees with this. As illustration, we note that a series of ‘must have’ hospitals under common ownership is more powerful than the exact same set of ‘must have’ hospitals each in separate hands. In the latter case the insurer could stagger the contract negotiations with each ‘must have’ hospital such that (in an extreme case) the insurer would not be out of contract with more than one at a time. The insurer could then focus all its energy and negotiating resource on each individual hospital negotiation. It could deploy whatever countermeasures were available (whereas having to deploy countermeasures in a series of local markets simultaneously could be prohibitively expensive). Negative media and customer impact would likely be contained within a single local market (and so less likely to draw national media attention or the concern of large corporate customers). By contrast, if contracts for all these

²¹ PFs, paragraph 6.240.

²² PFs, paragraph 6.170.

'must have' hospitals were negotiated at the same time and with the same hospital operator, the insurer's options in the relevant local markets are significantly reduced. Most importantly, were the insurer to go out of contract with all the hospitals simultaneously, there would be a very significant reputational/media impact with significant uncertainty caused to intermediaries and large corporates²³.

- 4.13 Therefore, the CC is correct that the 'more' must have hospitals the group owns the greater its power. This suggests that the CC can reduce the strength of BMI, HCA and Spire by reducing the number of 'must have' hospitals in their portfolios. It shows that the situation is improved for the insurer even though those 'must have' hospitals divested remain themselves 'must have' hospitals.
- 4.14 The CC, however, discounts the total number of hospitals as being a factor: *"We considered whether PMIs have weaker outside options when negotiating with a hospital operator that has, for example, a larger number of hospitals. In our view, this is unlikely to be the case for the following reasons. First, we note that this view is consistent with our finding on HCA, namely that it has the highest insured prices but is smaller than BMI, Spire, Nuffield and Ramsay on a number of metrics. Furthermore we considered that, in areas where hospital operators face strong competition, PMIs' outside options should be strong unless these competing hospitals are capacity constrained or there is some reason which prevents PMIs using these hospitals"*²⁴.
- 4.15 The first reason given here contains flawed reasoning. Simply because a smaller hospital group (HCA) has more market power than groups with larger hospital portfolios does not mean that larger portfolios do not confer some market power. The single exception does not disprove the hypothesis. HCA is deriving its market power from factors other than number of hospitals and this does not mean that number of hospitals is of no consequence (HCA would be even more powerful if it had more hospitals).
- 4.16 The second reason given is less clear but we understand the CC to be suggesting that if a group's hospitals are each in competitive markets, then no matter how many hospitals the group owns, the insurers will always have outside options. For example, a group with 10 hospitals all in competitive markets has the same bargaining position as a group with 60 hospitals all in a competitive markets – in each case insurers could (in theory) delist them as alternatives are available. In theory this may be true. However, in practice there are several constraints for an insurer dealing with 60 hospitals rather than 10, even if they are all in competitive markets.
- 4.17 First, delisting the group of 60 hospitals would, assuming all of the hospitals are of equal size, impact six times as many customers and consultants who may no longer get their first choice facility (even though a second choice is available). This will cause concern, complaints and media attention on a far greater scale.
- 4.18 Second, a group with 60 hospitals would control over 25% of private hospitals in the UK. Not offering this group would mean a significant restriction in choice for customers and so impacts the insurer's product proposition.
- 4.19 Third, in reality, the alternative facilities in each market will often not be perfect substitutes. Therefore, the insurer will still need to devote resources to communicating with

²³ As demonstrated in BHF's dispute with BMI in 2011/12.

²⁴ PFs, paragraph 6.241.

customers/intermediaries, handling redirections, managing people who are mid-treatment, and fielding complaints. This is on a far greater scale where 60 hospitals are involved.

- 4.20 Therefore, in our view, an increasing number of hospitals in the portfolio increases bargaining position even holding all else equal. This is because the costs for the insurer are greater in an out of contract situation due to of the number of markets and customers affected simultaneously.
- 4.21 The financial scale of a hospital group is also a dimension that confers power. A small insurer like WPA or Simplyhealth is in a particularly weak position against BMI or HCA because the additional operational costs the insurer must incur to go out of contract with a large group will quickly erode all of the small insurer's profits²⁵ yet the profit impact on the large hospital group will be much smaller. This means a large hospital group (with consequently significantly more financial resources) is likely to outlast a small insurer in a dispute situation. Therefore, financial scale alone contributes an element of market power.
- 4.22 Finally, we note that there is no evidence of overall group scale currently delivering any economies of scale benefits of customers. The prices at the largest groups (HCA, BMI and Spire) are systematically higher than smaller operators despite the additional volumes they undertake. Therefore, BHF sees little evidence that large scale groups benefit consumers, and significant evidence that scale is in fact leading to negative outcomes through market power.
- 4.23 In summary, BHF believes there are several dimensions through which the scale of a hospital group enhances its market power. It creates an AEC. A single hospital is much easier to negotiate with when it is not part of a larger group. All else equal, it is easier to negotiate with two groups of 30 hospitals than one group with 60 hospitals. Therefore, for the CC to rebalance the bargaining power between insurers and hospitals it needs to reduce the scale of the largest hospital groups.

NUFFIELD AND RAMSAY

- 4.24 BHF is concerned that no finding of market power was made against Ramsay and Nuffield. Both groups own a significant number of 'hospitals of concern':
- i. [redacted]
 - ii. [redacted]
- 4.25 These are significant shares and confer bargaining power. Insurers would not have sufficient outside options in these markets and the group would be able to raise prices significantly in these regions. We note approximately [redacted] of our spend with [redacted] was in 'hospitals of concern' and [redacted] was found to have market power.
- 4.26 The CC's conclusion appears to rely on:
- i. The lower profits of these two groups. However, we note that at various points the CC says its profitability analysis is conservative e.g. little adjustment was made for inefficient/under-utilised hospitals. [redacted] weak profits are very likely due to inefficiency allowed by "the quiet life" rather than because there are effective competitive constraints

²⁵ In revenue and profit terms, the larger hospital groups are several orders of magnitude larger than the smaller insurers.

on [X] The fact that [X] has earned excess profits over the past 3 years underlines its growing strength; this position is also understated given the share of [X] activity accounted for by NHS work²⁶.

- ii. The lower prices of Ramsay and Nuffield relative to HCA, Spire and BMI. It is true that *relative to HCA, BMI and Spire, the pricing of Ramsay and Nuffield is better*. However, prices remain high when compared to underlying costs of service and compared to other smaller groups/independent hospitals (which were not included in the CC's analysis).

4.27 Therefore, BHF believes both groups do occupy positions of market power. They should not be excused from any further consideration.

VERTICAL INTEGRATION

4.28 BHF welcomes the CC's findings that "*We did not receive evidence of Bupa's vertical linkages through its ownership of the Bupa Cromwell Hospital or any other insurers which might own primary care facilities being likely to lead to significant harm to competition*"²⁷. As BHF has explained there are typically significant synergies and benefits to vertical integration between funders (insurers) and provision.

4.29 However, BHF asks the CC to strengthen its position on the risks of vertical integration between hospitals and GP practices. BHF noted in paragraph 2.193 of its AIS Response the significant concerns in the NHS about vertical relationships between GPs and hospitals²⁸, so much so that NHS merger assessments must specifically consider whether a merger undermines the GP 'gatekeeper function'. Similar safeguards are not present in the private sector, although the negative impacts on competition and patient choice are the same²⁹. While the PFs raise some of the potential risks of hospitals controlling GP referrals, no firm safeguards are proposed.

4.30 Indeed, in our view, hospital operators acquiring GP practices has very similar effects to consultant incentive arrangements – it creates a financial tie to that hospital and can potentially influence the clinician's referral patterns.

4.31 BHF is concerned that hospitals will continue to expand into primary care as a strategy to secure referrals at the earliest point in the patient's journey (and so remove competition from other hospitals, as well as, choice for patients and insurers). This strategy is increasingly a 'feature' of the market³⁰.

²⁶ The CC explains that the allocation rules for revenues and capital between private and NHS activity will tend to over-attribute capital to NHS activity (which is actually lower margin) and so will understate the profits earned from private patients (see paragraph 10.2).

²⁷ PFs, paragraph 4.42.

²⁸ The Cooperation and Competition Panel (CCP) merger guidelines noted: "*The [GP] gatekeeper function is particularly relevant in vertical mergers involving GPs.... The CCP is concerned about the effects that such a [vertical] mergers may have on the incentives for GPs to refer patients to integrated service providers instead of allowing patients to exercise choice when they are entitled to do so... this has an adverse impact on choice per se, with associated risk of a reduction in competition. The ability to affect the GP gatekeeper function arises due to the integrated nature of the organisation and the fact that, usually, the management of an organisation will be able to direct its staff, or influence its behaviour*" (paragraph 6.98).

²⁹ The OFT does not have jurisdiction over a vertical merger of a hospital buying a GP practice. The OFT could only establish jurisdiction if the hospital already had a significant share of supply in the GP level. BHF asked the OFT to intervene in HCA's acquisition of Roodlane but the OFT was of the view that it could not.

³⁰ For example, the CC notes that HCA told it that Nuffield, BMI, The London Clinic, Aspen, and The Hospital of St John and St Elisabeth all offer or operate GP services (paragraph 53). There is also significant evidence of hospitals opening or acquiring 'satellite' diagnostic facilities which then channel referrals into the main inpatient facility.

- 4.32 The CC conducts an analysis of the effects of HCA's acquisitions of three private GP practices. It finds that "*currently*" these had not significantly impacted referral patterns. However, as the CC knows, these acquisitions took place during a period of intense competition authority scrutiny. As soon as the spotlight of the CC is removed, these patterns may change and there will be no ability to monitor them.
- 4.33 Indeed, the CC alludes to evidence which indicates that underlying intentions of these acquisitions were to control patient referrals³¹:
- i. The fact that, eight months after the acquisition of the Roodlane GP practice, HCA had to amend the shareholders agreement with Roodlane doctors such that "*the doctor shareholders would exercise their own independent clinical judgement in the selection of appropriate treatments, facilities and hospitals and would not be subject to the control or direction of HCA with respect to such judgements or the selection of hospitals*"³²; and
 - ii. An internal HCA strategy document which indicated that "*one of HCA's incentives to acquire the GP practices was to protect its main referral sources from potential intervention from PMIs*"³³.
- 4.34 We agree with the CC's conclusion that "*the ownership of GP practices is likely to reinforce HCA's current position (for example, by resisting attempts by PMIs to direct patients away from HCA, particularly in respect to key corporate clients) and that further acquisitions of GP practices would only further strengthen HCA's current position*"³⁴.
- 4.35 Given these concerns, BHF believes HCA, and indeed other hospitals (in particular 'hospitals of concern'), should be restricted from owning and acquiring GP practices and other primary care providers.

INSURER PRICE ANALYSIS

- 4.36 The CC conducts an analysis to rank the pricing of hospital operators. BHF agrees with the ranking found³⁵ – HCA and BMI being significantly more expensive than other operators. We are, however, concerned about the accuracy of the CC's statement [§<]
- 4.37 [§<]

“ONE IN, ALL IN”

- 4.38 The CC examines volume discount mechanisms used by hospital operators to 'incentivise' insurers to take all their facilities (or often to dis-incentivise insurers from recognising only some facilities or directing volume to rival hospitals). The CC finds that these mechanisms can create

³¹ We noted in our AIS response, paragraph 2.197, statements by the US parent of HCA about its explicit strategy in the US to increase its presence in primary care so as to increase the entry points into the HCA system and so to generate growth by keeping patients within the HCA system across the continuum of care.

³² PFs, paragraph 56, page 6(10)-19.

³³ PFs, paragraph 57, page 6(10)-20.

³⁴ Paragraph 6.141

³⁵ BHF is not in a position to comment on the differentials between operators or on the CC's representative basket given this data is redacted and BHF has been denied access to the Data Room.

"a strong incentive for full recognition [of all of the group's hospitals] being the default outcome of a negotiation"³⁶. They in effect deliver 'one in, all in' outcomes. BHF agrees with this.

- 4.39 The CC then concludes: "*in our view, these pricing agreements are a mechanism used by hospital operators to take advantage of their hospitals that face weak competitive constraints at the local level, i.e. they are not an additional reason for higher insured prices*" (emphasis added). We note, however, that 'one in, all in' mechanisms protect inefficient hospitals within the group's portfolio from market forces (allowing higher cost to remain in the system); they discourage more efficient entry; and, they discourage insurers from launching networks (e.g. low cost networks or specialist networks). Overtime this means prices remain higher than they would have been in the absence of these mechanisms. Therefore, 'one in, all in' mechanisms (like volume discount mechanisms), in our view, do provide an additional reason why insured prices are higher.
- 4.40 BHF is also surprised that the CC does not appear to refer to the case study of BMI using 'one in, all in' negotiations in relation BHF's ophthalmology network in 2007. See our response to Question 22 of the Market Request for further information.

³⁶ PFs, paragraph 6.187.

5 UNWARRANTED VARIATION

- 5.1 BHF welcomes the CC's provisional finding that clinician incentive schemes can create a distortion of competition through unnecessary diagnostic tests and outpatient consultations. We welcome also the recognition of the inherent risk of over-treatment³⁷ caused by the fee-for-service reimbursement model.
- 5.2 However, BHF asks the CC to reconsider two statements in the PFs related to unwarranted variation that are not based on sufficient evidence. BHF has significant concerns about the CC's decision to confine over-treatment of surgical procedures to being a marginal issue (in private healthcare and indeed healthcare in general) – this decision contradicts a significant body of evidence and is, in our view, outside the scope of the CC's competence.

THE NHS AS A BENCHMARK

- 5.3 The CC appears to discount BHF's case studies which indicate over-treatment of private patients on the basis that the comparative benchmark (in two of the case studies) is the NHS. At paragraph 8.128 the CC states: "*we note that comparisons with the NHS in England provide limited support as the NHS in England might tend to under-treat or under-diagnose*". This statement has no basis.
- 5.4 First, we are not aware of evidence that under-treatment or under-diagnosis is 'a feature' of the NHS. Indeed, we are surprised the CC asserts this. The *NHS Atlas of Variation in Healthcare*³⁸ shows significant variation in the treatment patterns across PCTs in England but does not find evidence of systematic under treatment across PCTs.
- 5.5 Second, when BHF benchmarks private healthcare activity against NHS activity, BHF seeks to use as the benchmark the intervention rate of the most interventionist NHS PCTs. The NHS benchmark used in the knee arthroscopy case study, for example, is based on the NHS PCT with highest rates of intervention. The fact that private intervention rates are found to be several orders of magnitude higher than this upper-bound in the NHS gives, in our view, significant credibility to the concerns of over-treatment illustrated by the case studies.
- 5.6 Third, even if the CC chooses to discount the two (of five) case studies submitted by BHF that use an NHS benchmark, the other three case studies remain relevant (as they do not use a NHS benchmark). These showed significant variation against published best medical practice or against treatment patterns of other private doctors.
- 5.7 BHF accepts that the NHS is not a 'perfect' benchmark for private practice. However, the CC is incorrect to completely discount the NHS as an informative benchmark or to discount the validity of BHF's case studies. These case studies provide evidence of over-treatment of procedures in private practice.

³⁷ BHF notes that the CC focusses only of over-treatment, which usually means a greater quantity of activity is delivered than necessary. However, unwarranted variation encompasses concerns also about over-diagnosis (where a higher specification test/treatment is delivered than is necessary) and practice that is not in line with evidence-based medical guidelines. These types of unwarranted variation are also of significant concern and stem from a lack of competition, information and oversight.

³⁸ The NHS Atlas of Variation, November 2011, NHS Rightcare. Some PCTs have significantly higher intervention rates than others – for instance the mean length of stays for elective breast surgery was found to vary by a factor of 11 between PCTs (after excluding the extreme observations).

ETHICAL AND REGULATORY CONSTRAINTS ARE SUFFICIENT TO PREVENT OVER-TREATMENT OF PROCEDURES

- 5.8 At paragraph 8.129 the CC states: “As regards advice on [surgical] treatment, we expect the ethical and regulatory constraints on behaviour to offset to a substantial extent any economic incentive for a consultant to offer advice that was otherwise than in the patient’s best interests. We would not rule out that on some occasions, some consultants might be influenced by economic incentives so as to over-treat, but we think such incidents are likely to be few and far between”.
- 5.9 The CC is making two significant judgments here.
- 5.10 First, it asserts that the ‘ethical and regulatory constraints’ to act in the patient’s best interest are sufficient to offset the economic incentives. The CC’s only explanation of what these constraints are is that: “in this context regulatory constraint refers to the potential for disciplinary action by the GMC”³⁹. The CC has not explained in any detail how it came to the view that these constraints are sufficient and BHF is accordingly unable to understand the basis on which the CC has reached this conclusion. It is, for example, not explained how the GMC is made aware of inappropriate behaviour or can build a case to take necessary action, where there is information asymmetry between the consultant and patient (so the patient is unable to assess whether or not the treatment was required) and there is no published data on consultant quality or activity. The CC therefore places significant reliance on constraints which are unsubstantiated and untested.
- 5.11 Second, the CC judges that incidents of surgical procedure over-treatment “are likely to be few and far between”. In essence, the CC is saying that over-treatment in surgical procedures is an issue at the margin⁴⁰. This is a remarkably strong position to take, which contradicts a significant body of international academic literature finding the existence of over-treatment in surgical procedures. There is no analysis by the CC in the PFs dispelling this literature.
- 5.12 Two case studies submitted by BHF also cast doubt on the CC’s view. There were significant and sustained reductions in the number of requests for Knee Arthroscopies⁴¹ and Wisdom Tooth Extractions⁴², both surgical procedures, when medical review processes were begun on these two procedures. In both cases, the introduction of a requirement that the consultant explain, in advance of treatment, why treatment is necessary resulted in marked reductions in the number of treatments requested by consultants. This suggests that thousands of treatments requested prior to such medical reviews may not have actually been justified.
- 5.13 BHF has significant concerns that the CC’s decision to confine over-treatment to a marginal issue will obscure further analysis of this issue by providers and insurers in future. For example, BHF anticipates significant challenges in engaging with providers on over-treatment if they are able to use CC precedent as a basis for refusing such engagement. If the CC is wrong, patients will continue to be put at risk. BHF therefore asks the CC to reconsider its position and to be transparent if it is unable to form a view because of a lack of expertise in this clinical area.

³⁹ PFs, paragraph 8.126, footnote 37.

⁴⁰ The extension of the CC’s argument is that ‘ethical and regulatory constraints’ should ensure that there is also no under-treatment by doctors (unless there were exogenous constraints, like funding constraints). Therefore, the CC would be suggesting that unwarranted variation in surgical procedures in general is prevented by the ethical and regulatory constraints on the doctor.

⁴¹ BHF OISR, Annex E.

⁴² BHF response to Q48 of the Market Request.

6 INFORMATION TRANSPARENCY

6.1 BHF agrees with the CC that there is:

- i. An absence of comparable information on consultants' quality or prices.
- ii. Insufficient information published by hospitals about quality, with the progress of the industry to date (e.g. PHIN) being inadequate.
- iii. A significant information asymmetry between patients and consultants, which puts patients in a vulnerable position.

6.2 The PFs, in our view, understate two important aspects about information transparency – the important role of the commissioner of care and the need for standardisation of coding. We ask that the CC reconsider these areas (in its findings and in remedies design). We note also our concern that the CC may overestimate the impact on improving information of the recent initiative by NHS England to publish consultant-level data in ten specialisms.

INFORMATION TRANSPARENCY FOR COMMISSIONERS OF CARE

6.3 The section on Information Availability in the PFs focuses almost exclusively on information available to patients. However, it is equally important to consider whether robust information is being made available by healthcare providers to commissioners of care (such as insurers and NHS commissioners).

6.4 There is strong evidence that PMI customers place high expectations on their insurers to achieve value for money from hospitals/consultants and to monitor the care provided⁴³. In effect, the insurer acts as the customer's agent in commissioning care. However, currently the provision of data by private hospitals to insurers is inconsistent and patchy, and by private consultants is almost entirely absent. This weakens insurers' ability to commission value for money care, to encourage competition between providers, or to identify and address unwarranted variation.

6.5 BHF, therefore, believes the CC should evaluate the sufficiency and quality of the information flowing from hospitals/consultants to insurers. This should cover:

- i. The type of information provided i.e. the relevance of the data to benchmarking and commissioning;
- ii. The quality of the information provided. Many providers provide only incomplete or patchy information;
- iii. The form in which the information is provided. It needs to be electronic (not paper) and usable in benchmarking;

⁴³ For example, customer research shows 89% of customers expect their insurer to monitor hospitals to ensure they offer high standards of care and follow best clinical practices (against only 4% who do not have this expectation); and, 87% expect their insurer to monitor consultants to ensure they offer high standards of care and follow best clinical practices (against only 5% who disagree).

- iv. The ability of the insurer to audit the data provided; and,
 - v. The restrictions imposed by providers on the use of that data. Currently, some hospital operators impose contractual provisions that prevent insurers from sharing/communicating performance information to customers.
- 6.6 Customers will benefit directly (both clinically and financially) from better information being provided by hospitals/consultants to insurers. Therefore, BHF asks the CC to reflect in its thinking and remedy design the need for improved flow of information to commissioners of care.

STANDARDISATION OF CODING

- 6.7 Critical to improving commissioning of care in private healthcare, and increasing competition between private healthcare providers, will be a greater standardisation in the way hospitals and consultants record activity data (i.e. the treatments actually delivered) as well as patient impairment information (i.e. the illness the patient presents with). Provision of information in a standardised way would significantly improve benchmarking, analysis of treatment variation, and ultimately competition between providers.
- 6.8 The CC has experienced first-hand the challenges in benchmarking hospital prices caused by the plethora of different coding structures across hospital operators. Insurers experience this every day. Navigating and mapping the different codes adds significant costs to BHF's business and ultimately customers.
- 6.9 The absence of this standardised approach is a market feature that itself creates an AEC. Yet there is little commentary or evaluation of this issue in the PFs. We ask that the CC reconsider this issue and the detriment it causes. A beneficial outcome from the CC investigation would be to ensure that private providers are obliged to adhere to mandatory participation in common coding (for both treatment activity and patient impairment information) and coding standards of conduct.

NHS ENGLAND INITIATIVE ON PUBLICATION OF CONSULTANT-LEVEL DATA

- 6.10 In paragraph 9.17 of the PFs, the CC notes the plans by NHS England to disclose individual NHS consultant's performance in ten specialisms. The CC is correct that this represents "*a significant increase in the information to GPs and patients, both private and NHS*". BHF, of course, welcomes the publication of consultant outcome data. However, we have significant concerns that the NHS England initiative is not sufficient to solve the substantial gap in the provision of information by private consultants. The initiative will give a "*significant increase*" in *the amount* of information (compared to the situation of no information today) but the usefulness of this information is much more limited.
- 6.11 BHF will comment further on the NHS England initiative in its response to the Remedies Notice. However, a summary of key concerns is:
- i. The initiative covers only 10 of 65 specialisms recognised by the GMC. This is a small subset. There are ambitions to extend this list, but no fixed timetable or committed plans.

- ii. In terms of consultant coverage, currently the NHS England initiative publishes data on under 4,000 consultants⁴⁴. This is a very small minority of NHS consultants in England. ***The initiative currently misses at least 70% of consultants in private practice in England***⁴⁵.
- iii. The data published is very limited. No more than a few procedures (often only one) are covered within each of the 10 specialisms.
- iv. The key "outcome" measure typically presented in the datasets is risk-adjusted mortality rate. However, as many of the procedures have extremely low mortality rates (often indistinguishable from chance), several of the datasets note that patients should not rank consultants according to this measure⁴⁶. Therefore, these mortality measures offer little additional information for patients on which to differentiate consultants or to insurers to meaningfully use in benchmarking or commissioning. Indeed, were a consultant systematically out of line on the metric of risk-adjusted mortality (i.e. unsafe) then one hopes the GMC, or relevant Royal College, would take action rather than leaving it to patients and insurers to discern through choice.

6.12 In our view, the key question on the usefulness of the data is "*Will it change patients' decision-making for the better?*" The NHS England initiative is a step forward, but not sufficient to actually change patient decision making. As such the CC should not count on this initiative in its current form to solve the AEC caused by lack of information on consultants.

⁴⁴ <http://www.rcseng.ac.uk/patients/surgical-outcomes>

⁴⁵ A National Audit Office (NAO) report, "Managing NHS hospital consultants", estimated that 15,754 consultants in England engaged in private practice in 2012.

⁴⁶ For example, the webpage of the Vascular Surgery dataset explains: "*Because the variation in surgeon outcomes was consistent with differences caused by random variation, we do not recommend that the surgeons in these tables are ranked by their mortality rate Consequently, ranking these surgeon figures would be misleading and it could make people draw the wrong conclusions about an individual surgeon's performance*".

ANNEX A: [✂]