



Private healthcare market investigation

Response to Remedies Notice

Bupa Health Funding

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1. EXECUTIVE SUMMARY

- 1.1 Bupa Health Funding ("BHF") welcomes the opportunity to assist the Competition Commission ("CC") in its consideration of remedies to address the Adverse Effects on Competition ("AEC") identified in the Provisional Findings ("PFs"). This response comments on the CC's Remedies Notice. [3<]
- 1.2 The AECs that the CC has identified are created by structural and behavioural features of the market that are interconnected and reinforce each other. BHF agrees that a comprehensive package of remedies is needed to unwind these interconnections and to make a material and lasting impact.
- 1.3 The AECs identified cause consumers hundreds of millions of pounds of detriment each year. The CC estimates, for example, that detriment of near £1 billion (in present value terms) arose from the market power of three hospital groups – Hospital Corporation of America ("HCA"), BMI and Spire – over the period 2007 to 2011. In fact, the level of detriment is significantly understated because it does not account for the lost welfare of the customers who have been forced out of private healthcare as a result of the AECs eroding value for money.
- 1.4 If the AECs are to be addressed and private healthcare is to be put on a sustainable footing, then the remedies need to deliver transformational change. Maintaining anything near the *status quo* leads to an untenable situation for many consumers within the next decade. If healthcare cost inflation continues at the rates observed over the past 15 years, private medical insurance ("PMI") will cost significantly more than what research shows many customers are willing to pay. The affordability crunch risks the industry contracting significantly. Unaided, the market can do little to avert this course; as the CC has found, insurers and patients do not have sufficient power to bring about change.
- 1.5 It is against this urgent need for industry transformation that BHF welcomes the CC's proposed remedies but strongly believes that the proposed remedies are not sufficient. The remedies must be strengthened and extended if they are to be effective.

ADDRESSING HOSPITAL GROUP MARKET POWER

- 1.6 The significant market power of many hospitals and large hospital groups is the critical concern. The CC found prices for self-pay patients and insured customers were higher because of (i) high barriers to entry for full-service line hospitals, and (ii) weak competitive constraints on many hospitals at a local level (including in central London). Over 100 hospitals across the UK were identified as facing "*insufficient competitive constraint*". The large hospital groups that own these "*hospitals of concern*" are able to leverage them (through bundling and tying) in negotiations with insurers to achieve higher prices across their whole hospital portfolios. The situation is particularly acute in central London, where HCA dominates the market with a revenue share of 55% in aggregate (and much higher levels in many specialisms). No insurer has countervailing buyer power against the large hospital groups. Indeed, the smaller insurers have so little bargaining power that the CC found they pay similar levels to self-pay patients.
- 1.7 The CC proposes three sets of remedies to address hospital market power; we discuss each below. We note that none of the remedies address barriers to entry directly, therefore this AEC will remain.

Divestments in cluster markets

- 1.8 The CC identifies approximately 20 cluster markets where a divestment by a hospital group that owns two hospitals in that cluster would introduce new rivalry.
- 1.9 BHF welcomes divestments as clear cut solutions that will deliver immediate improvements to competition in the affected areas. BHF believes, however, certain conditions must apply to any of the divestment remedies:
- i. The other main hospital groups, including Nuffield and Ramsay, are not suitable acquirers for the divested facilities. This would only increase the scale of these groups, replicating existing competition concerns. A further concern is that, if the other groups participate in the acquisition process they may see confidential pricing information, which might encourage them to raise prices to the insurers.
 - ii. Behavioural remedies are required to support the divestment package. These include: the appointment of a hold separate manager; a ban on consultant incentive schemes; the nullification of any contractual clauses that may prevent an insurer guiding patients to the divested facility; and, insurers being given the option (but not the obligation) to renegotiate existing contracts with the hospital group that has made the divestment.
 - iii. The divestment should take place within 6 months, failing which a divestment trustee should be appointed to effect the sale.
- 1.10 The CC must also take account of the Operating Company/Property Company structure of some of the large hospital groups. If the divested hospital business remains tied in to high rental payments to the property company (landlord), then it will be unable to compete effectively.
- 1.11 The most important cluster market is central London. This is an absolutely critical market to private healthcare in the UK because of its size and its importance to corporate customers of PMI. If HCA's stranglehold can be broken, the market has strong potential for competition.
- 1.12 BHF notes that:
- i. The CC must examine the central London market at the specialism-level. Effective competition must be created in each of the main specialisms, especially the ones that are growing very rapidly (e.g. oncology). HCA currently controls [X] of revenue in each of the nine main specialisms that together account for [X] of BHF's spend with HCA (we assume this is broadly representative for other insurers too). Within key specialisms, certain hospitals in the HCA portfolio individually account for a large proportion of BHF's total spend on that specialism in central London [X]
- 1.13 Revenue shares are more informative than admissions shares in assessing the competitive strength of London hospitals. For example, the [X]
- 1.14 [X] However, we emphasise that the proposed package in central London is not sufficient to deliver a competitive market.
- 1.15 BHF's own analysis shows that HCA must divest at least the inpatient and outpatient facilities of [X]. It is both practical and desirable that [X] are sold to separate acquirers. This would introduce [X] new competitors into central London, [X] with sufficient size and scope to be able to compete across the main specialisms. HCA itself would retain a share in central London of around [X] BHF strongly believes that any other divestment portfolio would not be sufficient

to create the suitable alternative provision necessary (in particular in key specialisms) in the event HCA withheld access to its portfolio.

- 1.16 BHF will comment separately on the proposed cluster divestments outside central London. However, we do note that, while welcome, these divestments will only be partly effective in some local areas and are unlikely to transform sufficiently the bargaining position between insurers and the main hospital groups [3<] Some of the main hospital groups are completely unaffected by these divestments, so retain their current scale and control of ‘hospitals of concern’. Even in the cluster markets there will remain high levels of concentration after the divestments, meaning that insurers’ and self-pay patients still have limited options.

“No tying” remedy

- 1.17 The CC proposes two possible remedies to address the risk of hospital groups tying their hospitals together.
- 1.18 The first, “Remedy 2(a)”, would prevent HCA, BMI or Spire from raising prices at ‘must have’ hospitals if an insurer changed its network composition. However, this remedy is too easy to circumvent and may have significant negative unintended consequences. Therefore, BHF considers Remedy 2(a) ineffective.
- 1.19 The second, “Remedy 2(b)”, would require HCA, BMI and Spire to present separate pricing for each hospital in their portfolio. While this transparency is welcome, and *may* increase insurers’ options against being presented with a single national price list, hospital groups can circumvent it and can also still charge excessive prices at ‘hospitals of concern’.
- 1.20 BHF considers Remedy 2(b) helpful in principle but insufficient in its current form as it will not stop leveraging or abuse.
- 1.21 Therefore, BHF believes that currently the two possible remedies to prevent tying will fail to achieve their goal. Remedy 2 (b) can be effective only if supported by additional remedies described below. If one does not fix the fundamental source of market power the proposed remedies would not work.
- 1.22 Finally, there is no reason we see why the no tying remedies should not also apply to Nuffield and Ramsay given each controls a large number of ‘hospitals of concern’.

Restrictions on expansion through PPU partnerships

- 1.23 The CC proposes a restriction on incumbent hospitals in Single (monopoly) or Duopoly markets from expanding their presence by partnering with the local NHS Private Patient Unit (“Remedy 3”). This remedy seeks to prevent further concentration of these already extremely concentrated markets. BHF welcomes this forward-looking protection. But we note that this remedy does not directly address existing levels of market power. It relies on successful entry and expansion by PPUs, which is highly uncertain (particularly due to the entry barriers in the market). The remedy also appears not to apply to central London where BHF has most concern about HCA using the tactic of PPU partnership to extend its dominant position. This remedy must be applied to HCA in central London. Therefore, Remedy 3 is welcome, but not sufficient to resolve the AEC or detriment currently identified.

Significant harm is unresolved in Single and Duopoly markets

- 1.24 The remedies proposed by the CC to address hospital market power are therefore insufficient. They do not transform the negotiating position of insurers and offer only very limited relief to a minority of self-pay patients.

- 1.25 The major concern is that there is no constraint on the conduct of hospitals in Single or Duopoly markets. BHF estimates that Single/Duopoly hospitals account for over [X] “hospitals of concern” identified by the CC outside central London. These are the markets where self-pay patients face the highest prices and where insurers have the most limited choices. High entry barriers insulate these markets from competition. Yet, currently there is no remedy targeted at repairing the AEC or detriment in these markets.
- 1.26 Self-pay customers will therefore see no improvement in these markets in which they face the highest detriment in terms of price. Insurers will equally gain no additional buyer power in these markets. Indeed, [X] will still have over [X] of their revenues from BHF in Single/Duopoly markets (we assume the position for other insurers will be similar). [X] already has over [X] of its revenues in Single/Duopoly markets, and this proportion may increase after cluster divestments. The three groups will also remain extremely large hospital groups from a scale perspective. Therefore, their bargaining position will remain strong. One has only to look at the fact that Ramsay, a much smaller hospital group with significantly fewer Single/Duopoly hospitals, earned excessive profits in three of the five years looked at by the CC to illustrate the significant market power the other main groups retain.
- 1.27 The CC must, therefore, consider further remedies to apply to Single/Duopoly markets.
- 1.28 BHF believes the following package would be proportionate and significantly more likely to be effective in addressing the AEC in Single and Duopoly markets than the proposed remedies:
- i. A price control of the approximately 30 hospitals in Single markets. There is very little prospect that competition will develop in these markets; they are in effect natural monopolies. Price control is, therefore, a reasonable response. BHF recognises price controls can be complex and costly (and so has constrained the control to as small a subset of hospitals as reasonable), but the cost is small in comparison to both the significant direct benefits that would accumulate to affected self-pay patients and the substantial benefits to all insured customers from an improved insurer bargaining position against the hospital groups; AND
 - ii. Divestment of certain Asymmetric duopoly facilities by the large groups. These divestments can be targeted at a short list of facilities within the [X] portfolios. Once divested from the main group, insurers will benefit from (a) the improved bargaining position against the standalone facility, and (b) the fact that the main group is now smaller, owns fewer “hospitals of concern”, and has a greater share of its revenues in competed markets.
- 1.29 In the event price control is not possible, further divestments will be required. This would include some of the main Single hospitals e.g. [X]
- 1.30 BHF considers the above package is proportionate given the very significant detriment that is currently unresolved by the CC’s proposed remedies package. The above package, in conjunction with the cluster divestments, would result in a significant rebalancing of bargaining power between hospital groups and insurers that would improve the likelihood of consumers getting better value for money.

Additional AECs in relation to hospitals

- 1.31 BHF noted in its PFs response that two further AECs relating to hospital groups, not identified by the CC, also cause harm and require remedy:

- i. Vertical mergers. 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 i.e. it influences referral patterns. The NHS recognises these concerns and has safeguards in place e.g. specifically requiring the competition authority in the NHS (Monitor) to assess the impacts of a merger on GPs' independence. The current safeguards in place in the private sector are not effective and a remedy must be put in place. In addition, some recent acquisitions must be reversed.
- ii. Hospital group scale. The scale of a hospital group confers market power (incremental to that derived from the 'hospitals of concern'). 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. This involves a far larger number of customers (in particular large corporates), consultants and intermediaries being negatively affected. 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.

ADDRESSING CLINICIAN INCENTIVE SCHEMES

- 1.32 BHF agrees with the CC that incentive arrangements between private hospital operators and consultants give rise to an AEC. BHF strongly agrees with the need to remove such arrangements (whether they are short-term or long-term), as is contemplated in "Remedy 4".
- 1.33 The most clear-cut and effective remedy would be to prohibit all incentive arrangements between consultants and private hospital operators. There are good precedents for this action internationally and this action would be consistent with GMC *Good Medical Practice* guidelines.
- 1.34 BHF accepts that there is a case for exempting from any prohibition the provision of certain services and / or facilities by hospitals or hospital operators to consultants where these are provided at full market rates (provided that there is full disclosure of these arrangements and such exemption is strictly controlled). BHF would also recognise a case, in the interests of avoiding uncertainty, for a very limited *de minimis* exemption for arrangements that are below a particular financial threshold.
- 1.35 If the CC is minded to introduce an exemption in respect of particular types of incentive arrangement (e.g. consulting rooms), BHF's view is that there should be an obligation on both hospital operators and private consultants to disclose publicly the details of these arrangements. This additional transparency would allow any non-exempted arrangements to be reported by other doctors, hospitals, patients or insurers, and, if necessary, investigated and sanctioned by the GMC.

ADDRESSING INFORMATION AVAILABILITY

- 1.36 The CC identified three AECs relating to information availability. BHF strongly supports remedies to improve quality and patient decision making and choice. However, while the

remedies proposed by the CC take the industry forward they need to be strengthened and enhanced if the fundamental gaps in information provision are to be filled.

- 1.37 In general, BHF notes the following about information remedies:
- i. The provision of the specified information must be mandatory on all relevant private providers (hospitals and consultants). There must be sanctions for failure to comply.
 - ii. The remedies should be future-proofed so that they will keep pace with developments in the NHS, rather than frozen at today's standard.
 - iii. The information must facilitate comparison across providers, as this is essential to fostering competition.
 - iv. The information must actually change patient decision-making. It must be relevant, accessible, usable and actionable. 'More' information is of no value unless it changes behaviours.
 - v. The information must be objective, with checks on its accuracy and sanctions if providers do not maintain the required standard of conduct.
 - vi. The information must be available to patients AND to commissioners of care and GPs who use the data on the patient's behalf.

Information available to patients on consultant quality

- 1.38 The CC proposes to recommend that the health departments in Scotland, Wales and Northern Ireland collect and publish consultant performance data, as is done by NHS England ("Remedy 5"). BHF considers Remedy 5 to be ineffective. It will not improve patient decision making and will not remove the AEC.
- 1.39 The NHS England initiative is extremely limited in coverage: the datasets cover only ten specialisms; only a few procedures are covered within each specialism; and combined the initiative covers under 4,000 consultants. Therefore, it misses the vast majority of activity and, at best, captures under a quarter of consultants in private practice in England. A significant concern is that the key 'quality' measure published tends to be risk-adjusted mortality rate. This is not an effective metric upon which patients (or commissioners of care) can rank consultants.
- 1.40 In BHF's view, a far superior remedy would be to mandate that:
- i. All private consultants complete relevant clinical registries; AND
 - ii. The data in those registries is made available to commissioners of care and parties like Dr Foster; AND
 - iii. Where a clinical registry does not exist steps are taken to fill the gap.
- 1.41 This would significantly increase the data available on individual consultant performance and quality. It would also create a market in which insurers and intermediaries (like Dr Foster) compete in how that data is analysed and presented to customers to inform patient decision making.

Information available to patients on consultant fees

- 1.42 BHF strongly supports the first element of the CC's "Remedy 6": the requirement for all private consultants to provide a fee quotation in writing and obtain financial consent in advance of treatment. This proposal will improve transparency of fees, will avoid unexpected shortfalls for patients, and, if presented early enough in the treatment journey, will give the patient an option to switch consultant if fees are too high. However, BHF believes this element of the remedy must be strengthened through defining the information that the consultant must provide to the patient in the fee quotation. For example, if a treatment requires input from an anaesthetist or a particular diagnostic test, the lead consultant must include fee estimates for these components of care. Consultants must also provide patients with revised quotations in writing (including justification) if treatment costs are expected to change.
- 1.43 BHF has some concerns with the second element of Remedy 6: the requirement for all private consultants to publish the fee for their initial consultation on the web. This remedy may give rise to unintended consequences e.g. a 'race-to-the top' if patients perceive higher prices to mean higher quality. There is also complexity in that consultants may agree different consultation fees with different insurers. Therefore, BHF proposes that it should be mandatory for private consultants to publish their outpatient consultation fees for self-pay patients on the web AND notify insurers of their outpatient consultation fees, if it is not already agreed, so that insurers can communicate the fee to insured customers at pre-authorisation.

Information available on hospital quality

- 1.44 BHF strongly welcomes Remedy 7: the requirement for private providers to collect HES and PROMs equivalent data. This will have significant benefits. However, to unlock the value of this remedy three additional provisions must be explicitly recognised:
- i. It must be mandatory for all private providers and insurers to use a patient's NHS number (or a standard agreed number for international patients), so that there is a unique and consistent identifier with which the various datasets can be compared and a patient's progress through their treatment journey can be tracked.
 - ii. The remedy must be future-proofed such that the data published keeps pace with the NHS (e.g. as PROMs is rolled out to more treatments).
 - iii. Commissioners of care must be given access to the raw datasets (rather than a selected pre-packaged metric) so that they can use this in benchmarking providers.
- 1.45 BHF considers a competent, independent body like the NHS Information Centre to be the suitable custodian of the datasets. BHF has significant concerns about the Private Hospital Information Network ("PHIN") in its current form being given the role – to date, PHIN has not delivered meaningful progress in the sector.
- 1.46 In addition to the above, BHF considers the following to be critical to addressing the AEC:
- i. A mandatory industry transition to ICD-10 in impairment coding.
 - ii. A minimum patient safety metrics dataset produced by all private hospitals.
 - iii. Mandatory industry participation in a programme to standardise charge codes by expanding the CCSD coding structure beyond the procedure codes covered today. To be

clear, a move away from CCSD to OPCS-4.6 would not be workable or advantageous and would create significant cost and uncertainty for the industry.

- iv. The removal of all contractual clauses which prevent insurers from sharing relevant information about hospital quality or performance with customers.

ADDRESSING CONSULTANT GROUPS

1.47 BHF's PFs response asks the CC to re-evaluate the evidence in relation to consultant groups, in particular, groups in anaesthetics and ophthalmology. The CC's findings on anaesthetist groups are not consistent with the evidence cited in the PFs. The larger anaesthetist groups are creating an AEC – they directly reduce patient choice in the local market and they charge higher prices. There is also a large number of consultant groups in ophthalmic services that are negotiating collectively (with a dominant position nationally) with the effect of reduced choice and higher prices.

1.48 Relevant remedies to address this AEC would include:

- i. A restriction on the size a group can reach within a local market on the basis of number of members and/or share of activity in the local market.
- ii. A restriction on groups negotiating collectively on behalf of consultants or for joint fee setting by consultants.
- iii. Full disclosure by consultants of whether or not they are members of a group.

2. INTRODUCTION

- 2.1 The Competition Commission's Provisional Findings ("PFs") present evidence of five Adverse Effects on Competition ("AEC") in private healthcare. Alongside the PFs, the CC published a Remedies Notice on 28 August 2013 in which it consults on the proposed package of remedies to address the identified AECs.
- 2.2 This response provides comments on the consultation questions in the Remedies Notice. BHF has separately provided comments on the substance of the PFs, which should be read in conjunction with this response.
- 2.3 Please note [3<]

ADDITIONAL AECS REQUIRING REMEDY

- 2.4 BHF's PFs response asks the CC to reconsider the evidence related to four additional areas in which, in our view, AECs arise:
- i. **Consultant groups:** The evidence in the PFs indicates strongly that many anaesthetist groups occupy dominant market positions that reduce patient choice and from which they can, and do, charge higher prices. There is also clear evidence of an AEC [3<]
 - ii. **Hospital group scale:** The scale of the larger hospital groups gives them additional market power (over and above that derived from their 'must have' facilities), which creates an AEC. More far-reaching divestments must be pursued to shrink the size of these national groups. This is necessary to rebalance the bargaining position between large hospital groups and smaller insurers.
 - iii. **Vertical mergers:** Hospital operators are increasingly acquiring a presence in primary care (e.g. GP practices). This negatively impacts both patient choice and competition. In effect they can operate very similarly to a consultant incentive scheme in terms of influencing GP referral patterns. The NHS has significant concerns about vertical arrangements that may compromise the impartiality of the GP, and safeguards have been put in place. Private healthcare needs similar safeguards.
 - iv. **Hospital coding standardisation:** The absence of standardisation in the coding of activity and impairments across hospital operators is a market feature that restricts competition and adds cost. Hospital operators are in a position to resist the attempts by insurers to move to a standardised, more efficient system.
- 2.5 The CC's proposed set of remedies will need to be extended to address the additional AECs that arise from the market features described above.

PROCEDURAL CONCERNS

2.6 BHF notes points of concern in terms of process:

- i. [REDACTED]
- ii. BHF is yet to receive the full list of 'hospitals of concern' from the CC. This response, therefore, comments on the CC's proposed remedies using the information provided by the CC in May 2013 during the working paper phase and Appendices 6.6 to 6.7 of the PFs.
- iii. BHF was not granted access to the Data Room on 9 and 10 September 2013, restricting BHF's ability to comment on the PFs and proposed remedies.
- iv. BHF is concerned that both self-pay patients and smaller insurers may not be given sufficient scope to comment on the CC's remedies. We understand that these parties have not been given access to the CC's proposed divestment packages despite the fact that the smaller insurers and self-pay patients bear a disproportionate share of the consumer detriment¹.

[REDACTED]

STRUCTURE OF RESPONSE

2.7 This response is structured as follows:

- i. Section 3 sets out the significant risk the industry faces within the next decade if substantial action is not taken.
- ii. Section 4 comments on the CC's remedies proposals to address the AEC of hospital market power.
- iii. Section 5 comments on the CC's proposed remedy for clinician incentives.
- iv. Section 6 comments on the CC's proposed remedies to address the AECs in relation to information availability on hospitals and consultants.

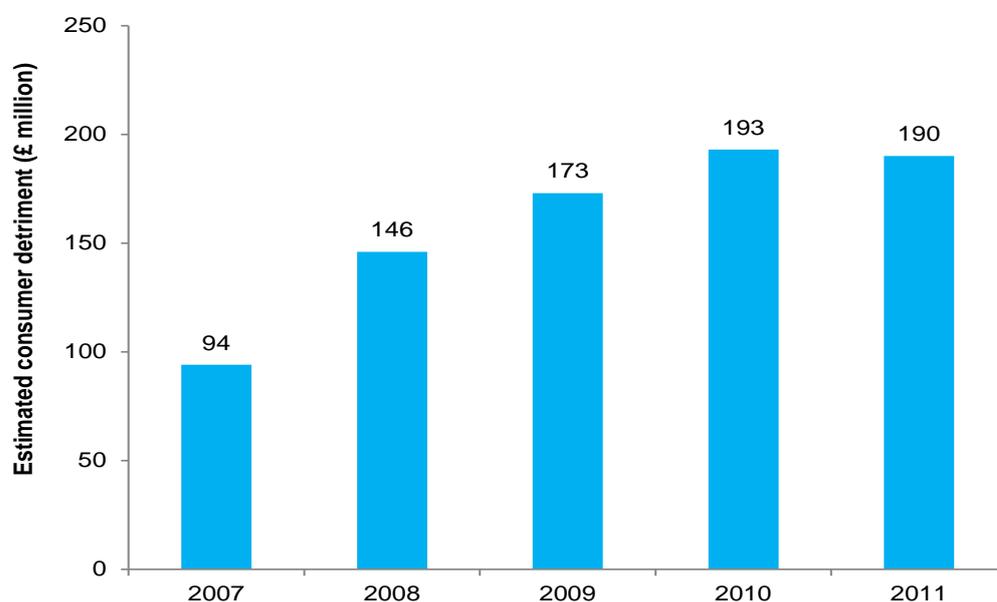
¹ Self-pay patients and smaller insurers pay the highest prices given they have no buyer power.

3. THE CASE FOR CHANGE

Significant harm already established

- 3.1 The PFs show that significant consumer detriment has already occurred due to the AECs. Figure 1 below shows the CC's initial estimates of detriment caused by the three hospital groups HCA, BMI and Spire. These are based on the profitability analysis².
- 3.2 The estimated detriment has risen significantly over the five years despite the stagnant market and totals near £1 billion (in 2012 prices) over the period.

Figure 1: CC estimate of consumer detriment from HCA, BMI and Spire



Source: Provisional Findings, Table 10.1 (p351)

- 3.3 The CC considers the estimate to be conservative:
- It does not account for any inefficiency in the performance of the hospitals that soft competition may have allowed them to enjoy. Indeed, the PFs note that there is surplus capacity in the industry³. This will make profits appear lower (through inflating the capital employed and deflating ROCE), leading detriment to be understated.
 - It uses a cost of capital at the very top end of the range considered by the CC, meaning the difference between ROCE and cost of capital is minimised.

² The CC found that the hospitals' Return on Capital Employed (ROCE) exceeded the cost of capital on a significant and sustained basis. This differential between ROCE and cost of capital is used to calculate the detriment.

³ For example, the PFs explain: "Evidence suggests that most private hospitals in the UK have substantial spare capacity A BMI presentation to PMIs also described a problem of over capacity in the industry, and stated that on average only 40 per cent of hospitals were profitably utilized" (paragraph 5.29).

- iii. The CC excludes EBIT and capital employed earned from NHS activity. The allocations between NHS and private work are driven by revenue. However, as margins are lower on NHS work than private work, this revenue allocation rule will over attribute EBIT to NHS activity and so understate the excess profits earned from private customers.
 - iv. It excludes the excessive profits earned by Ramsay in 3 of the 5 years looked at by the CC.
 - v. The estimate captures the detriment from the other identified AECs (e.g. a lack of information on consultants and hospitals) only "to some extent" but certainly not in full. It captures little of the harm caused from ineffective consultant competition, for example.
- 3.4 BHF believes the detriment estimate is **significantly underestimated**. It does not capture the welfare losses of those customers excluded from the private healthcare due to high prices over the period. For example, over the same 5 years of excess profits shown above, over 700,000 people exited the PMI market⁴.
- 3.5 The magnitude and trend in detriment gives reason for strong action. However, the need for transformational change is even more pressing looking forward. Any assessment of remedy proportionality and effectiveness must take this future state into account.

The prognosis for private healthcare is concerning

- 3.6 There have been sustained high rates of healthcare cost inflation over the past 15 years. Private hospital/clinic revenues rose from £1.1bn in 1995 to £4.1bn in 2011 – a rise of over 130% in real terms⁵. Private specialist revenues rose from £0.6bn in 1995 to £1.6bn in 2011 – a 65% rise in real terms. Therefore, PH spend by customers has risen at around 8% per annum.
- 3.7 A number of drivers underpin healthcare cost inflation. Some of these are structural in nature e.g. increased disease prevalence (e.g. due to obesity) and healthcare innovations that broaden the array of treatments available. These will continue to push healthcare costs upwards. However, some of the drivers are due to the conduct of market participants themselves e.g. exercising market power, financial incentives, and unwarranted variation. Addressing these drivers could slow inflation significantly.
- 3.8 The urgent need to slow private healthcare cost inflation is clear. Significant input cost inflation, combined with the uncertainty of the economic downturn, has caused an affordability crunch in the PMI market⁶. Premiums have risen rapidly and customers have either exited PMI entirely or traded down policy cover. By lives covered, the PMI market was the same size in 2012 as it was in 1995 and PMI penetration in the UK is at its lowest level in 20 years. As costs rise and people exit, those left in the market are left to shoulder an ever-increasing share of costs, prompting further exits.
- 3.9 The critical concern is the limited headroom for further premium inflation. Figure 2 shows the findings of research on Personal customers commissioned by BHF in December 2010. Conjoint analysis was used to reveal the willingness to pay range for different customer groups. It

⁴ Laing and Buisson, Health Cover 2013.

⁵ Laing and Buisson, *Private Acute Medical Care – UK Market Report 2012 (First Edition)*.

⁶ Around 80 pence of each pound of premium flows through to PH providers (consultants and hospitals), meaning cost inflation from PH providers feeds directly into PMI premiums. A combination of unit price rises from PH providers and an increased volume of care delivered per patient causes claims cost per patient to increase well ahead of general inflation.

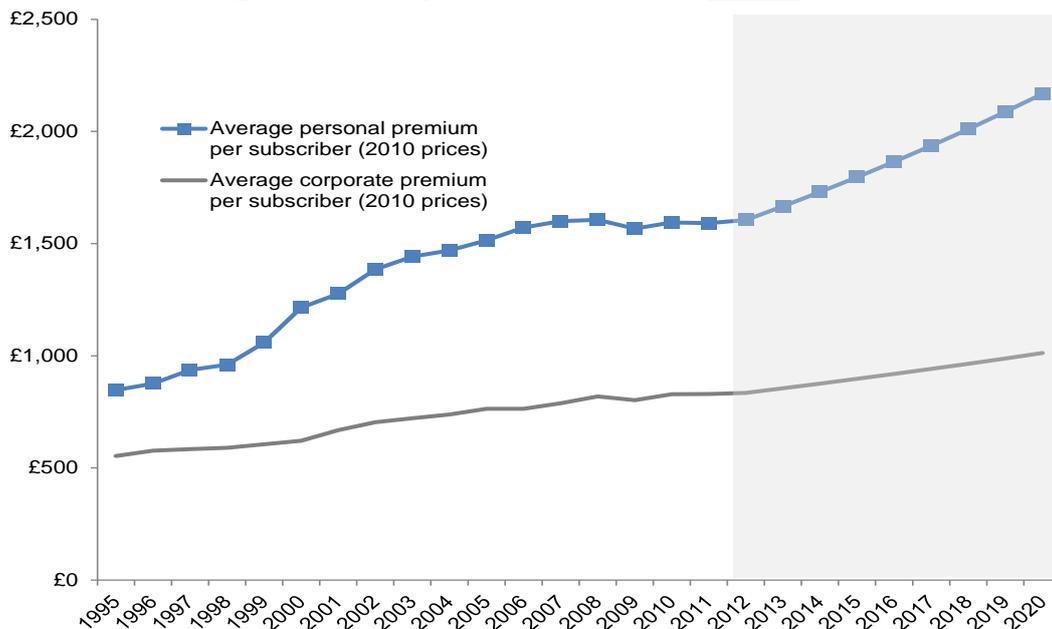
indicated that the premiums were already towards the upper bound of what most customer groups were willing to pay for PMI; the “average” person being just beneath the top limit. This finding is consistent with the continued decline observed in the Personal market as premiums have risen.

Figure 2: [✂]

3.10 The corporate market is also experiencing this crunch as evidenced by the CC’s own survey of large corporates⁷. 78% of large corporates say that cost remains the main influence on their decisions to buy, or to continue to offer, healthcare benefits⁸. Corporates have down-traded the level of cover offered to employees (e.g. allowing lower benefit limits before the employee must self-fund) and also limit the proportion of their workforce offered PMI benefits.

3.11 If healthcare costs continue to increase at current rates, it seems highly likely the PMI sector will contract further by 2020. Figure 3 shows the simple illustration that, were premiums to continue to rise in line with the long-term trend, the average Personal premium would be around 35% higher in real terms (and well outside most willingness to pay ranges described above) and corporate customer premiums would be over 20% higher in real terms. Increases of that magnitude will tip a large number of people out of the market.

Figure 3: Trends in average annual PMI premiums, 1995-2020, in 2010



prices

Source: Laing and Buisson 2012

Note: 2013-2020 estimates based on long term linear projections

3.12 There is some positive news for the sector:

⁷ The CC’s survey of large corporates notes the comments from employee benefits advisor Towers Watson that a tipping point may be approaching: “increasingly, its clients found the existing model of healthcare provision unsustainable as a result of rising costs” (AIS Appendix F, paragraph 51).

⁸ Employee Benefits survey 2013, http://www.employeebenefits.co.uk/Journals/2013/05/29/n/v/c/EBS_0613.pdf

- i. Real disposable income per capita is expected to show modest growth to 2020, following a period of stagnation through the financial crisis⁹. However, this rate of increase is projected to be far more moderate than during the 15 years prior to the crisis – a period during which the Personal market declined by over 25% and during the latter half of which growth in the corporate market plateaued¹⁰. Further, the rate of growth is likely to be much slower than the predicted increase in healthcare cost inflation.
- ii. The movement of care out of (more expensive) inpatient settings into outpatient/day-case settings may yield a net saving. The PFs, however, show that the move from inpatient to day-case care in the private sector has been “less pronounced” than observed in the NHS¹¹.

3.13 These factors are, however, unlikely to provide sufficient support to counteract the significant price pressure, making the industry prognosis highly concerning. Far-reaching remedies are required from the CC to put the industry on a sustainable footing. Competitive tension must be injected on a sufficient scale and pace to:

- i. Allow an immediate downwards cost correction as the significant market power of large hospital groups is removed. The CC’s detriment estimate indicates that customers are already overpaying significant amounts due to this market power.
- ii. Allow market forces to thrive in private healthcare provision. This will place a much-needed focus on efficiency and fixing practices that do not deliver value for money.
- iii. Allow commissioners of care to identify and remove any unnecessary cost in the system from unwarranted variation.
- iv. Allow insurers the flexibility to introduce lower-cost PMI products that encourage more customers back into the risk pool.

3.14 Information remedies will take longer to make an impact, but are also fundamental because:

- i. A clearer focus on quality from hospitals and consultants will help the sector demonstrate the value for money necessary to encourage consumers to use private healthcare (ahead of the NHS).
- ii. More standardised information from hospitals and consultants will allow transaction costs to be reduced for insurers and consumers.
- iii. Increased comparability with the NHS will allow patients to move more easily and transparently between NHS care and private care along their treatment journey.

3.15 **The remedies package needs to have a significant, lasting impact. And it must do so quickly.** The sector needs to take significant strides towards improved value for money within the next two years.

⁹ Real disposable income per capita (as reported by the Office of National Statistics) showed a compound average growth rate of 2.9% per annum over the period 1993-2007. The Office of Budget Responsibility forecasts a 0.9% per annum rate of growth between from 2013 to 2018. Real disposable income per capita fell by 0.2% per annum between 2007 and 2012.

¹⁰ Laing and Buisson estimates that, by lives covered, the corporate market grew by just under 7% between 2000 (5.4 million) and 2007 (5.8 million). These gains were completely eroded during the recession (to 5.3 million lives in 2012).

¹¹ PFs, paragraph 2.17.

4. ADDRESSING HOSPITAL MARKET POWER

- 4.1 This section comments on the CC's proposed remedies to address hospital market power.
- 4.2 The two AECs that the CC's proposed remedies are seeking to address are:
- i. High barriers to entry for full service hospitals; and
 - ii. Weak competitive constraints in many local markets including central London.
- 4.3 The Remedies Notice explains that “[t]ogether the [two] features ... give rise to AECs in the market for hospital services that are likely to lead to higher prices for self-pay patients in certain local markets and to higher prices for insured patients for treatment by those hospital operators (HCA, BMI and Spire) that have market power in negotiations with insurers”¹².
- 4.4 BHF notes two further concerns about hospital market power relevant to this section:
- i. the AEC resulting from the scale of the largest hospital groups and their leverage of monopoly and duopoly hospitals; and
 - ii. the AEC relating to hospital operators acquiring primary care facilities (e.g. GP practices).
- 4.5 The section is structured as follows:
- i. Part 1 explains the general principles BHF believes the CC must consider in reaching its decision on remedies to address hospital market power.
 - ii. Part 2 comments on the remedies options considered for central London.
 - iii. Part 3 comments on the remedies options considered in relation to BMI and Spire.
 - iv. Part 4 comments on the “no tying” remedies proposals.
 - v. Part 5 comments on the restrictions on expansion by incumbent operators with market power through PPU partnerships.

¹² Remedies Notice, paragraph 7.

PART 1: ADDRESSING HOSPITAL MARKET POWER

- 4.6 The CC's proposed remedies will not be sufficient to address the identified AECs or to remove the detriment caused to both self-pay patients and insured customers by hospital market power.
- 4.7 We agree that divestments in Cluster markets will improve competition in these local areas. In particular, we welcome divestments in central London which, if the correct facilities are divested, could be effective in improving competition in central London.
- 4.8 However, we have significant concerns that:
- i. Even after divestments in cluster markets, the main hospital groups BMI, Spire, Nuffield and Ramsay will retain significant numbers of 'hospitals of concern' and significant scale. The position of insurers, and smaller insurers in particular, will not be fundamentally rebalanced as it needs to be.
 - ii. Hospital market power in very highly concentrated local markets, the monopoly and Duopoly markets, is not addressed by the proposed remedies. Self-pay customers will certainly be left to continue to pay high prices in these markets. The CC proposes 'no tying' remedies which are aimed at addressing, indirectly, the risk of the 'must have' facilities being used to extract higher prices in negotiations with insurers. However, as discussed below (paragraph 4.128), the proposed remedies will not be sufficient in constraining a hospital group's ability to leverage its 'must have' facilities in a negotiation as both remedies proposed face significant risks of circumvention and unintended consequences.
 - iii. The remedy proposing a restriction on incumbent hospital operators further expanding through partnering with NHS Private Patient Units (PPUs) does not address the existing AEC and consumer detriment; it offers only some protection against the situation deteriorating further. While this protection is welcome, it does not fundamentally change competition or insurer bargaining power.
- 4.9 BHF is concerned that this package of remedies will not be sufficient when you consider their impact relative to the significant consumer detriment resulting from the AECs.

RELEVANT CONTEXT

- 4.10 Four pieces of evidence in the PFs have significant bearing on the design of remedies.

High barriers to entry and expansion

- 4.11 The PFs show that there are significant entry barriers into inpatient hospital services, with barriers in central London in particular being high. There is very little evidence of entry in the past 5 years. A number of the entry barriers are intrinsic market features (i.e. they are always present). For example, the high capital costs involved in building a hospital and the fact that

many local markets do not have sufficient demand to support a new hospital entrant (where incumbents are already present).

- 4.12 The CC acknowledges in the Remedies Notice that "*none [of its proposed remedies] would directly address barriers to entry*"¹³. Therefore, the continued presence of significant entry barriers means that the 'threat of entry' remains only a weak constraint on incumbent hospital operators.
- 4.13 BHF notes also that there are barriers to expansion. It is difficult and costly for a hospital to move into a new specialism (i.e. one not already offered) and the CC notes there is relatively little evidence of hospitals entering new specialisms in the past 5 years. A hospital can more easily expand the supply of a specialism it already offers. However, even within specialisms already offered, BHF submits that barriers to expansion can be high. In particular, moving into more complex treatments within a specialism like oncology requires significant investment in specialist equipment, staff training, and in finding appropriate consultants.
- 4.14 There are two implications for remedies design of barriers to expansion:
- 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 Annotated Issues Statement response. Many PPUs may appear to 'offer' the 16 specialisms considered by the CC, 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 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 a hospital offers one of the 16 specialisms it could become a credible competitor (and choice for insurers) in that specialism within a short period of time.
 - ii. It can be very costly for a "general" hospital to refocus its staff and assets into more high-complexity treatments even in specialisms that the general hospital already offers. Therefore, divesting a general hospital may not introduce significant new rivalry in specialisms with high-complexity treatments.

A large number of hospitals face little or no competitive constraint at the local level

- 4.15 The PFs found over 100 hospitals across the UK that face "*insufficient*" competitive constraints at a local level and are 'hospitals of concern'. These facilities have local market power and give hospital groups that own them significant market power in negotiations with insurers.
- 4.16 BHF has not had sight of the CC's final list of 'hospital of concern'. It was not published in the PFs. Table 1 below has been compiled by BHF based on the CC's put back papers sent to BHF in May 2013 to check accuracy and confidentiality. The table appears broadly consistent with the CC's conclusions in the PFs at an aggregate level (but may not be an exact match). The table looks only at hospitals of concern outside of central London, so does not show the 'must have' hospitals of HCA.

¹³ Remedies Notice, paragraph 13.

4.17 The hospitals are divided into four main categories:

- i. **“Single”** - the hospital is a local monopoly.
- ii. **“Duopoly”** - there are only two operators in the local market meaning the market remains very highly concentrated and the hospital has market power. The duopolies are further segmented into *“Asymmetric duopoly”*, where one of the two operators dominates, and *“Symmetric duopoly”*, where the hospitals are of more similar scale and scope.
- iii. **“Other hospitals of concern”** – hospitals in areas where there are more rivals but these rivals do not place sufficient competitive constraint. This is likely to include many of the areas that the CC refers to as “Cluster” markets where one operator owns more than one facility in the local area (and were it to divest a facility, local rivalry would increase).
- iv. **“Not of concern”** where the CC (provisionally) found no concerns¹⁴.

Table 1: Segmentation of hospitals of concern outside central London⁽¹⁾

Category	BMI	Nuffield	Ramsay	Spire	Independent	All
Total hospitals investigated	56	31	22	36	49	193
Hospitals of concern	[X]	[X]	[X]	[X]	[X]	[X]
Single	[X]	[X]	[X]	[X]	[X]	[X]
Duopoly - Asymmetric duopoly	[X]	[X]	[X]	[X]	[X]	[X]
Duopoly - Symmetric duopoly	[X]	[X]	[X]	[X]	[X]	[X]
Other hospitals of concern	[X]	[X]	[X]	[X]	[X]	[X]
Not of concern	[X]	[X]	[X]	[X]	[X]	[X]
Sufficient constraints in a multi-provider environment	[X]	[X]	[X]	[X]	[X]	[X]
Smallest hospital in an asymmetric duopoly	[X]	[X]	[X]	[X]	[X]	[X]

Notes:

(1) BHF has compiled this segmentation based on put-back information provided by the CC in May 2013 and Tables 6.1 of PFs.

4.18 Each of the main hospital groups owns a number of hospitals of concern. [X]

4.19 Table 2 below shows the proportion of BHF’s 2012 claims spend with each group that was within the ‘hospitals of concern’¹⁵. In particular, it should be noted:

- i. [X] of BHF’s spend with BMI is in ‘hospitals of concern’ in BMI’s portfolio. [X]. Further, in absolute terms the amount of BHF’s spend in BMI’s hospitals of concern [X]

¹⁴ BHF has argued in its PFs response that the degree of local market power has been understated by the CC because it has not conducted a specialism-level analysis. Were the analysis conducted at a specialism level, some of the ‘not of concern’ hospitals would be reclassified as ‘of concern’.

¹⁵ We assume BHF spend patterns are broadly representative of other insurers and so indicative of the market position.

- ii. [redacted]
- iii. [redacted]
- iv. [redacted]

Table 2: BHF claims spend across each hospital group’s ‘hospitals of concern’, 2012

Group	Total BHF claims spend in 2012 (£ million)	% of total group spend at hospitals of concern				
		Single	Asymmetric Duopoly	Symmetric Duopoly	Other hospitals of concern	Total in hospitals of concern
BMI	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Spire	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Nuffield	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]
Ramsay	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]	[redacted]

Source: BHF claims analysis

4.20 [redacted]. Where insurers do not have sufficient (even any) alternative options at a local level, the hospital group knows that revenues in these areas are not at significant risk even in an out of contract situation. Further, the hospital group knows it can also potentially raise prices significantly in these areas [redacted]

4.21 As noted in our PFs response, given that the CC did not conduct its analysis at a specialism level, the above shares are in fact conservative.

Local concentration leads to higher prices

4.22 The PFs found a statistically significant relationship between local market concentration and higher self-pay prices. That analysis indicated that “*reductions of around 20 percentage-points in hospital’s weighted average market share are expected to lead to, on average, a 2 to 6 per cent decline in average price charged to self-pay patients, with our preferred estimates lying between 3 and 4 per cent*”¹⁶.

4.23 So, all else equal, prices for self-pay customers will be around 10% higher in Single markets than in markets with four or more competing hospitals.

Small insurers have no bargaining power

4.24 The PFs found that all insurers, other than BHF and AXA, have no buyer power (and even BHF and AXA did not have sufficient buyer power to offset the market power of the main groups). Indeed, some small insurers were found to be paying as much or more than self-pay patients.

4.25 The absence of any buyer power for small insurers is not surprising given (a) the significant shares of the large hospital group’s portfolios in which insurers have little or no choices, and (b) the size of the large hospital groups relative to the smaller insurers. For a small insurer, the additional operational and reputational costs of going out of contract with a large group for any

¹⁶ Remedies Notice, paragraph 14.

length of time quickly become prohibitive, as most small insurers already operate on thin profit margins in the highly competitive PMI market. By contrast, for the large hospital group, losing the business of one of the small insurers will make only a minor impact on a hospital group's revenues or profitability. Therefore, the hospital group knows it has the market position and financial scale to outlast the smaller insurer in any dispute.

- 4.26 In summary, the key points for remedies design from the above pieces of evidence are:
- i. Entry cannot be relied upon to discipline the conduct of incumbents.
 - ii. Hospitals can face constraints in expanding supply even within specialisms already offered, in particular for higher complexity treatments. Entering new specialisms is very challenging.
 - iii. Each hospital group owns a large number of 'hospitals of concern', meaning a significant proportion (most often the significant majority) of its revenues from an insurer face limited competitive threat. [X]
 - iv. Self-pay patients are already paying significantly higher prices in Single and Duopoly markets.
 - v. The bargaining position of insurers, in particular smaller insurers, against larger hospital groups needs to change fundamentally if any customers are to see better value for money.

DIVESTMENTS IN CLUSTER MARKETS

- 4.27 The CC's proposed divestment remedies focus on around 20 Cluster markets (which includes central London). These divestments are welcome as they will increase rivalry in these local markets (in many cases from two hospital operators to three). They will also reduce the scale of some of the larger hospital groups. This will lead to *some* improvement in outcomes for both self-pay patients and insured customers within a short period of time.
- 4.28 However, BHF does not believe that these divestments in cluster markets are sufficient to address fully the AEC or consumer detriment.
- 4.29 First, Table 1 above demonstrates that a significant proportion of 'hospitals of concern', the facilities that confer market power to the groups, are in Single and Duopoly markets. We expect these will be largely unaffected by the Cluster divestments. [X]of the [X] hospitals of concern outside central London are likely to be unaffected. Therefore, the main hospital groups will retain significant market power from these hospitals.
- 4.30 Based on our analysis of Table 1, some of the main hospital groups are likely to be left broadly, if not wholly, unchanged by cluster divestments:
- i. [X]
 - ii. [X]
 - iii. [X]

- 4.31 Therefore, insurers' (and therefore customers') bargaining positions are not transformed as they need to be – small insurers will still have little buyer power.
- 4.32 Second, it would seem likely that in many cases the divestment will create at best three competitors of similar scale and scope in a local market. More often, however, there is likely to be an asymmetric triopoly due to differences between the operators in capacities and specialisms. This may mean that rivalry remains restricted even after divestment (e.g. there may remain only two Oncology providers in the region). Indeed, even in a best case scenario where the divestment creates three equally-sized rivals, the local market would remain “*highly concentrated*”. Using one measure of market concentration, the Herfindahl-Hirschman Index (HHI), a market with three equally-sized firms has an HHI of over 3,300¹⁷. The HHI would rise as the market shares of the three hospitals become more asymmetric. As an illustrative comparison, the central London market in which the CC has found ineffective competition has an HHI under 3,300 (based on BHF's spend data). Therefore, the gains from increased competition in these cluster markets are unlikely to be transformational.
- 4.33 Third, there is a risk of unintended consequences from focusing only on cluster facilities. Following divestments of cluster facilities, groups like [X] may actually increase in bargaining power [Y]. Further, it seems highly likely that, in those markets in which a hospital group owns two facilities and is obliged to divest one, the group will seek to sell the smaller and weaker of the two. For example, the groups may seek to divest its interest in the local PPU rather than the group's own facility in the area¹⁸.
- 4.34 Fourth, given the relatively limited number of areas in which cluster divestments will take place, only a minority of self-pay patients will see improved pricing from increased local rivalry. In these markets the CC's pricing analysis indicates that the move from two to three fascia will lead to self-pay prices falling by between 3 and 4 per cent. While this is a material improvement, it is not transformational and seems highly unlikely to be sufficient to bring prices more in line with costs. The majority of self-pay patients will be in Single and Duopoly markets where there will continue to be little or no effective constraint on price.
- 4.35 Fifth, even after the divestments the large groups will still have significant scale; BMI, Spire and Nuffield in particular. As explained in the BHF PFs response, this scale provides additional bargaining power to hospital operators.
- 4.36 In summary, BHF welcomes the cluster divestments, and agrees that they will be partially effective in addressing an element of the hospital group market power. But BHF does not believe the cluster divestments are sufficient to rebalance bargaining power in favour of insurers. They will also not resolve the existing AECs and detriment in approximately [X] of the hospitals of concern outside central London.

¹⁷ The OFT and CC Merger Assessment Guidelines explain that a market in which the HHI exceeds 1,000 can be categorised as 'concentrated' and one in which it exceeds 2,000 can be categorised as 'highly concentrated'.

¹⁸ In general PPUs tend to be weaker competitors due to their focus on a narrower set of specialisms, the challenge of negative patient and consultant perceptions, and their continued obligations to NHS patients. See Annex A of BHF's Original Issues Statement Response.

ADDRESSING MARKET POWER IN SINGLE/DUOPOLY MARKETS

- 4.37 As described above, BHF has significant concerns that the proposed remedies do not provide effective constraint on hospitals in the significant majority of Single/Duopoly positions. Self-pay patients and insured customers are provided little or no protection against abuse by the incumbents in these markets. It seems highly likely that a significant proportion of the existing consumer detriment will be unresolved.
- 4.38 We do not believe that either the threat of entry or the threat of a Competition and Markets Authority (“CMA”) investigation provides any meaningful constraint on the pricing of the incumbent operators.
- 4.39 The process of a Competition Act investigation is slow and costly. Excessive pricing cases are, by their nature, complex. Given the number of Single/Duopoly markets it is unrealistic to assume that the CMA could devote sufficient resources on an on-going basis to investigate what may be a number of complaints in different local markets.
- 4.40 BHF has carefully considered various options to address the market power of hospitals in these Single and Duopoly markets. We believe the CC should consider the following package: price control at the Single hospitals AND targeted divestments of key Asymmetric duopoly hospitals from the large hospital groups¹⁹. Note, however, if the CC is unwilling to pursue a price control, the divestment list should be expanded to include the largest Single hospitals. For example, [X] which is critical to corporate business.

Alternative A: Price control at Single Hospitals + Targeted divestments of Asymmetric Duopoly hospitals

Price control of Single hospitals

- 4.41 The most effective way to constrain the risk for both self-pay patients and insurers in Single areas is a price control. In the Remedies Notice the CC says it is not minded to consider this option. The CC says that the remedy would not address “*the root cause of the problem*”²⁰. However, BHF notes that no other remedy proposed is yet doing so in Single/Duopoly markets and customers remain exposed to consumer detriment. Therefore, the CC must reconsider price control.
- 4.42 BHF appreciates that price control is complex and is a ‘non-market outcome’. However, BHF would envisage that the control would only be applied to Single hospitals; [X]. These facilities face no competitive constraint and are akin to natural monopolies given the barriers to entry in these markets. Price control is a proportionate and appropriate response in this scenario.
- 4.43 Self-pay customers in these markets would benefit directly and materially from the control. The bargaining position of insurers on behalf of their customers would also be improved against the main hospital groups if the groups could no longer threaten to increase prices in markets where

¹⁹ To be clear, this package of divestments would be in addition to those contemplated in the cluster market divestments (i.e. they are not a replacement for the cluster market divestments).

²⁰ Remedies Notice, paragraph 81.

insurers have no alternative choice at all. This would lower overall prices for the hospital group (so insured customers outside the Single area would also benefit significantly).

- 4.44 BHF agrees that it would take resources to set up a price control mechanism. However, the scale of the detriment caused on an on-going basis without such measures is very likely to outweigh these costs²¹.
- 4.45 To illustrate the potential benefits from the control:
- i. BHF's current spend is [x] per annum in the [x] Single hospitals.
 - ii. Using BHF's market share to gross up this figure for all PMIs, this would indicate private medical insurers spend [x] million at Single hospitals.
 - iii. Self-pay customers are likely to spend approximately [x] per annum in these facilities²².
 - iv. A ballpark estimate, therefore, is [x] of private spend in these facilities.
 - v. Were the control to lower prices by [x] in these markets²³, the direct saving for customers would be around [x]. We consider this a conservative estimate.
 - vi. Insurers would also realise indirect savings from an improved negotiating position against the main hospital groups.
- 4.46 BHF is not best placed to estimate the costs of implementing a control. However, it would be surprising if the costs of regulating prices for [x] hospitals outweighed the significant benefits that would arise from the price control. As an illustrative benchmark: the CC itself employs over 100 staff and has an operational budget for 2013/14 of £18 million. We expect the cost of the price control would be much lower.
- 4.47 Further, there may be options in terms of the nature and scope of a price control that would constrain the costs but still deliver benefits. For example, rather than undertaking bottom-up costing of services to construct a tariff, the control could rely on a system where the price of treatments in controlled markets is linked/pegged to the average price of a similar treatment at a like-for-like hospital in competitive local markets (correcting for geographic cost differentials).
- 4.48 Therefore, it would seem highly likely that the control could be implemented with similarly proportionate running costs. These costs should be funded (on a pro rata basis by revenue) by the hospitals subject to the control.

Targeted divestments of Asymmetric duopolies

- 4.49 The control would not protect customers or insurers in duopoly markets; asymmetric duopoly markets in particular being a concern. Therefore, in addition to the control, BHF believes a short list of targeted divestments in these asymmetric duopoly markets, to ensure that there are providers outside of the main hospital groups, would assist in rebalancing the bargaining position for insurers.

²¹ Further, in the counterfactual with no price control, it is likely that significant costs may be incurred in parties pursuing complex Competition Act investigations.

²² [x]

²³ [x]

4.50 It is much easier for an insurer to negotiate with a standalone hospital than it is when the same hospital is inside a larger group. Any dispute is contained to one local market rather than the insurer having to deal with disputes in a number of local markets simultaneously. The insurer's negotiating position (and therefore the position of end customers) is improved in this scenario because:

- i. The insurer will now likely be better able to weather financially a dispute period for longer than the hospital.
- ii. The negative reputational impact from the dispute will likely be contained to local media, whereas a dispute with a large, national group may reach a wider audience through the national media²⁴. The uncertainty caused for the insurer's customers during an out of contract dispute causes significant damage to the insurer's reputation. Therefore, if the coverage of the dispute is confined to a smaller audience, the insurer is in a better position (as it is placed at less risk).
- iii. A dispute in one local market is less likely to upset large corporates or intermediaries, whereas a dispute that affects many markets simultaneously causes significant ripples and uncertainty with these important stakeholders.
- iv. The insurer can devote its limited resources fully to that one market. This improves the likelihood and credibility of finding countermeasures to the exertion of hospital market power. For example, the insurer could fund a redirection programme that pays customers to travel to hospitals further away. This option would become prohibitively expensive and very hard to administer if a large number of markets (and so a large number of customers) are affected. The insurers could also threaten to sponsor the entry of another provider (e.g. a PPU). Again, this option would be prohibitively expensive if it had to be replicated across many markets at the same time.
- v. There are significant operational efficiencies from having to deal with only one market rather than many. For example, the number of customer complaints to deal with during the dispute will be more manageable.
- vi. If the standalone hospital chooses to behave anti-competitively (e.g. raising prices) there is a more clear-cut and focussed competition law case to take to the CMA than when the power/conduct of that hospital is hidden within a wider group.
- vii. The hospital may itself recognise the 'self-defeating' impact of spoiling the local PH market with damaging tactics and uncertainty. This offers some protection to the insurer.

4.51 Finally, the situation of the insurer is also improved against the main hospital group that divested the 'must have' hospital. The group is now of smaller scale and has fewer 'must have' hospitals.

4.52 BHF believes a short-list of divestments could be targeted at the hospital group's largest Asymmetric duopoly facilities (noting that some of the larger asymmetric duopolies are already

²⁴ As occurred when BHF and BMI went into dispute in late 2011.

in the CC's cluster hospital divestment list). These facilities would be sufficiently large to be facilities that can stand alone²⁵. The recommended list would include at least:

- i. [X]
- ii. [X]

Alternative B: Targeted divestments of the largest Single and Asymmetric Duopoly hospitals

4.53 If the CC is unwilling to pursue a price control, then a more far-reaching set of divestments is required from the main hospital groups. In addition to the Asymmetric Duopoly hospitals in paragraph 4.52 above (and the hospitals forming part of the Cluster divestments), the following Single hospitals should be included:

- i. [X]
- ii. [X]
- iii. [X]

4.54 The above facilities have been selected because of their size (each accounting for over [X] in BHF spend per annum), coverage of specialisms and importance to corporate business. [X] in particular is essential for corporate business given its Single position in [X]. These facilities confer significant bargaining power to the hospital groups that own them²⁶.

GENERAL PRINCIPLES TO APPLY TO DIVESTMENT PACKAGE DESIGN

4.55 BHF sets out briefly here some general principles that the CC should consider in forming its divestment packages.

Creating an effective and sustainable competitor

4.56 The intention of the divestment is to create effective and sustainable rivalry in the local market. The divested business, therefore, needs to be able to compete. BHF is concerned, however, that a divested business may be restricted in its ability to compete (and reduce prices) if it remains locked in to high rental payments to the property company (landlord) owning the underlying property. BHF understands that a number of the large hospital groups (such as BMI) use Operating Company - Property Company (OpCo-PropCo) structures. The divestment package must take account of these structures, ideally selling the operating company and underlying property together to the new owner.

Suitability of purchasers for divested assets

4.57 BHF expects that there will be significant interest from parties in acquiring the divested assets. These are likely to include private equity and international healthcare operators (US, Middle Eastern and European). We note, for example, that [X].

4.58 In BHF's views, some potential purchasers are not suitable:

²⁵ The listed facilities should **not** be sold to another large hospital group.

²⁶ BHF has sought to keep this a short list in the interests of practicability and so has focussed on the Single hospitals of most importance. However, it should not be interpreted that the Single hospitals not on this list are not also important in negotiations.

- i. We would have significant concerns if the purchaser is one of the other existing large hospital groups (BMI, HCA, Nuffield, Ramsay, Spire). This will simply expand that group's scale and could increase the proportion of the group's portfolio that comprises 'must have' facilities. It would not be appropriate, for example, to have HCA buy non-London divested facilities from BMI/Spire as this would expand HCA's already significant scale. It would also not be appropriate for Ramsay to acquire Single and Asymmetric duopoly facilities and so extend its scale and proportion of spend that is in areas where competition is weak. We also have concerns about other groups participating in the sales processes and in so doing gaining sight of confidential pricing data at the divesting groups.
- ii. A single purchaser may seek to buy a bundle of the divested hospitals. However, the CC must take care that this single purchaser does not itself become so large that it is able to exert market power over insurers (particularly smaller insurers). BHF particularly raises this concern in relation to central London.

4.59 In principle, we would not object to another insurer purchasing a divested hospital (i.e. vertical integration). However, if that hospital is a 'must have' hospital or is particularly critical to serving corporate customers, then steps would need to be taken to ensure other insurers still have access to that facility on fair and reasonable terms. For example, if an insurer were to buy [X], that insurer could gain significant advantage over other insurers for the national business of these corporate accounts (e.g. if it raised prices at [X] while giving itself preferential terms).

Timetable for divestments

4.60 The timetable for divestment does not need to be longer than six months. If the divesting groups are unable to reach a deal within this period a divestment trustee should be appointed to make the sale within three months. It is in our view unfair to consumers for there to be a significant delay before the remedies take effect.

Divestments must be part of a wider remedies package

4.61 To be effective, divestments will need to be supported by a number of behavioural remedies:

- i. A hold-separate manager should be appointed immediately to avoid the divesting group using the period until divestment to redirect key staff (consultants), assets (medical equipment) and patient activity from the divested hospital to its retained facilities in the local area. The divesting group must not be allowed to devalue the competitive position of the divested facility.
- ii. A ban on consultant incentives should take immediate effect for the divesting group to avoid it 'poaching' all the key consultants from the divested hospital.
- iii. Any contractual clause in existing contracts between insurers and hospital groups that restrict the insurer's ability to guide volume away from the hospital group or to launch products and networks must be removed. If these clauses remain, the group may remain protected from the new rivalry created by the divestment.
- iv. We have assumed that insurers would be given the opportunity to negotiate terms with the divested facility. However, to maximise consumer benefits insurers must also be given the option (but not the obligation) to renegotiate existing contracts with the hospital groups that have divested facilities. Following divestment, the main hospital groups will have changed in size and composition. It would be inappropriate to allow the group to

retain, for the full terms of the existing contract, the higher prices that it had negotiated when its market power was stronger.

PART 2: REMEDIES TO ADDRESS CONCENTRATION IN CENTRAL LONDON

- 4.62 The evidence in the PFs sets out a clear case for a structural remedy in central London. This critical market is highly concentrated and is becoming increasingly so. Concentration is particularly high in key specialisms like oncology and cardiology. HCA is in a dominant position facing “weak” competitive constraints. The evidence of HCA’s significant and sustained excess profitability indicates the presence of barriers to entry and that prices are too high.
- 4.63 Central London is an absolutely critical region for PMI, due to its importance for many large corporate accounts. Escalating costs in central London will result in corporates retracting PMI benefits to staff in the capital and across the UK. The detrimental impact on consumers caused by high concentration in central London, therefore, extends to customers across the UK and is understated by HCA’s own excess profitability.
- 4.64 In BHF’s view, the *only* way to remedy the AEC in central London is for HCA to divest a package of several hospitals and to roll back its influence of primary care referrals. No remedy that does not include divestments by HCA will be effective.
- 4.65 Divestments must be targeted at fostering competition at the specialism level, not just at an aggregate share level. HCA derives its strength from its dominance of key specialisms. Divestments should also be based on market share in terms of *revenues*, rather than *admissions*, because admissions are not like-for-like from a funding perspective.
- 4.66 BHF believes a divestment package including at least the inpatient and outpatient facilities of [X], would be effective and proportionate in creating new rivals of sufficient size across specialisms. We discuss below how we arrive at this package.

The CC’s proposed remedies package for central London

- 4.67 [X]
- 4.68 [X] However, BHF can emphasise here that the CC’s proposed package will not achieve sufficient competition, in key specialisms in particular.
- 4.69 Therefore, BHF believes the CC’s proposed package is insufficient and must be expanded.

THE RELEVANT CONTEXT IN CENTRAL LONDON

- 4.70 The CC has collated clear evidence of the concentrated nature of the central London market and HCA’s dominant share within it:

*“Our analysis of shares of supply at the aggregated level indicated that **central London is a highly concentrated market** and that **HCA has high shares of supply relative to its competitors**. HCA has a share of supply in central London **above 45 per cent** by*

admissions (inpatient and inpatient plus day-patient) and above 55 per cent by revenue (patient and total).²⁷

4.71 In terms of market share of total admissions, HCA is around four times larger than its next closest competitor, The London Clinic (“TLC”)²⁸, and almost eight times larger than its second closest competitor the Bupa Cromwell. Table 3 shows that HCA’s market share of certain key specialisms and treatments is even more concentrated than at the aggregate level.

Table 3: Analysis of HCA’s market shares in central London

CC finding in the PFs	
1	HCA has the highest share by admissions in 12 of 17 specialties (reviewed by the CC and this review omitted a number of smaller specialisms in which HCA is also dominant)
2	HCA has a share by admissions of over 40 per cent in 11 of 17 specialties
3	HCA has a share by admissions of over 55 per cent in each of the four most common specialties: <ul style="list-style-type: none"> • [60-70] per cent in oncology • [60-70] per cent in trauma and orthopaedics • [50-60] per cent in gastroenterology • [60-70] per cent in obstetrics and gynaecology
4	HCA has a share of over 60 per cent in specialties that might be considered more complex (i.e. oncology and cardiology)
5	HCA has a share by admissions of over 50 per cent when considering only those central London providers that have critical care level 3 beds
6	HCA has a share by inpatient admissions of over 60 per cent in tertiary treatments

Source: PFs paragraph 6.127

4.72 HCA also has a significant majority of private hospital capacity in central London. It holds “over [50] per cent” of overnight bed and consulting room capacity, “over [45] per cent” of operating theatre capacity, and “over [65] per cent” of critical care level 3 beds. The next largest operator is again TLC, who the CC reports as accounting for only [10-20] per cent of capacity in overnight beds, theatres, consulting rooms and critical care level 3 beds²⁹.

4.73 HCA’s market share in central London is protected by the high barriers to entry and expansion that exist in this market. The CC’s examination of evidence on barriers to entry led it to provisionally conclude “that finding a site and obtaining planning permission for a new general hospital site, **certainly in central London but also in some other parts of the UK, could raise the costs and the risks of entry or expansion, thus giving incumbent hospitals a cost advantage and, therefore, constituting a barrier to entry**”³⁰. For example, it took several years for TLC to open a new oncology centre despite already having an established presence and reputation within central London.

4.74 Indeed, the CC’s review of HCA internal documentation indicates that HCA has itself encountered difficulties in finding suitable sites to expand in central London, particularly with regard to The London Bridge Hospital: “We note, further, that internal documents indicate that HCA has itself found difficulties in identifying suitable sites in central London. It was

²⁷ PFs paragraph 6.125.

²⁸ Ibid.

²⁹ PFs paragraph 6.130.

³⁰ PFs paragraph 6.65.

encountering capacity constraints at London Bridge Hospital, for example, which it described as **'landlocked'** (emphasis added)³¹.

- 4.75 These barriers to entry protect the advantageous locations enjoyed by HCA's hospital portfolio. As noted by the CC, "HCA hospitals are well-located and near important areas of central London (eg Harley Street, the City of London) while non-HCA hospitals are not all located in comparable areas"³².
- 4.76 The CC found evidence that HCA is using its strong market position in central London to charge higher prices than other private hospital operators. Specifically, the CC notes that "...compared to the other four largest hospital operators (i.e. BMI, Spire, Nuffield and Ramsay), HCA charged significantly higher prices to PMIs" and that "...a proportion of the price differences was not explained by the central London location"³³ (of HCA's facilities). As noted in BHF's PFs response, the CC's price index analysis is likely to understate the expensiveness of HCA given that the basket would not include 'less common' treatments in specialisms like oncology and cardiothoracic surgery which HCA dominates.
- 4.77 The provisional finding of market power is further supported by the CC's analysis of HCA's profitability. This showed that HCA has "been earning returns substantially and persistently in excess of the cost of capital"³⁴.
- 4.78 The CC also notes that HCA's ownership of GP practices reinforces its current market position and that future GP acquisitions will further strengthen this position. Similarly, the CC identifies HCA's ability to outbid competitors for future PPU management contracts as another way in which HCA is able to strengthen its market position³⁵.

4.79 [REDACTED]

Figure 4: [REDACTED]

- 4.80 The CC's provisional findings on HCA's market power, therefore, align with BHF's own experience. Competition can only be introduced by increasing rivalry in central London through divestments of existing facilities.

CONCENTRATION AT A SPECIALISM LEVEL

- 4.81 Figure 5 shows the dominant position HCA has within BHF's central London hospital spend across a number of key specialities. HCA's market share within a specialism is reflected by the height of the column, the quantum of BHF's spend is represented by the width of the column. HCA has a market share of [REDACTED] in each of the 9 top specialisms (these 9 specialisms account for around [REDACTED] of BHF's spend with HCA in central London)³⁶.

³¹ PFs paragraph 6.61.

³² PFs paragraph 6.135.

³³ PFs paragraph 38.

³⁴ PFs paragraph 43.

³⁵ PFs paragraph 6.143.

³⁶ It should be noted that this figure reflects data at a relatively high level of aggregation by specialism – within certain sub-specialisms, particularly high-complexity treatments, HCA's market share is even higher.

Figure 5: [redacted]

4.82 Figure 6 shows the facility breakdown of BHF's spend with HCA in central London [redacted]

Figure 6: [redacted]

4.83 Figure 7 below segments BHF's total HCA spend by specialism at the hospital level. Key observations are:

- i. [redacted]
- ii. [redacted]
- iii. [redacted]
- iv. [redacted]

Figure 7: [redacted]

BHF'S PROPOSED DIVESTMENT PACKAGE

4.84 To address the AEC identified in the central London market, sufficient facilities would need to be divested by HCA to reduce concentration and promote competition within key specialisms.

4.85 There would need to be:

- i. [redacted]
- ii. [redacted]

4.86 Figure 8 presents a breakdown of HCA's market share of BHF central London spend (at the specialism level). Market shares are presented for (i) HCA's current total hospital portfolio (column A); (ii) the combined market share of [redacted] (column B); (iii) individual hospital market shares (columns C to G); and (iv) total HCA market shares reflecting certain divestment scenarios that BHF has considered (column H to J).

Figure 8: [redacted]

4.87 [redacted]

4.88 [redacted]

4.89 [redacted]

4.90 [redacted]

4.91 [redacted]

4.92 Considering the scenarios presented above, it is clear that to reduce effectively HCA's high market share in a wide range of specialities divestments need to be targeted at HCA's [redacted]. The divestment of the [redacted] and [redacted] will most meaningfully reduce HCA's market share in the high spend specialities of [redacted] to more competitive levels. It will also effectively reduce market shares across a range of other, lower spend specialisms.

[X]

4.93 [X]

Suitability of purchasers

- 4.94 BHF has commented in paragraph 4.57 above about the general criteria that should apply to the suitability of purchasers. To reiterate, it would not be appropriate for another national hospital group [X] to acquire [X]
- 4.95 In central London, BHF considers a further criterion should be applied: [X], each hospital should be sold to a different acquirer. [X]
- 4.96 BHF sees no reason why it would not be possible to find two separate acquirers for these facilities. BHF expects there will be significant interest from investors to acquire these facilities.
- 4.97 If [X] is purchased by another insurer, provisions would need to be put in place to ensure that other insurers could continue to get fair terms of access to the facilities.

Divestments need to be supported by behavioural remedies

- 4.98 Divestment of HCA facilities are a necessary step in improving competition in central London. They are not, however, sufficient on their own and must be accompanied by a set of behavioural remedies (see 4.100).

CONSULTATION QUESTIONS

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

- 4.99 Divestments go a long way towards addressing the AEC in central London but they are not sufficient by themselves. They must be accompanied by a set of behavioural remedies, see 4.61, and noting:
- i. It is critical that consultant incentives are banned so that HCA is unable to poach key consultants away from the facilities it divests. Failure to do so may result in consultants shifting to the facilities that HCA retains, blunting the competitive impact of the divestments.
 - ii. HCA's expansion within central London through PPU joint ventures must be restricted. HCA has actively pursued this expansion strategy to entrench its position in central London. Post divestments (and potentially using the proceeds of the divestments) HCA may seek to re-establish its dominant position in key specialisms through acquiring smaller PPUs in central London.
 - iii. [X]
- 4.100 In terms of commenting on the criteria the CC has used to specify the divestment package, BHF assumes the CC is pointing to paragraph 19 of the Appendix of the Remedies Notice. The five main factors listed are each sensible for specifying the divestiture package. However, to this list BHF considers the following must be added:

- i. Hospital size and importance must also be assessed in revenue terms (and not just based on admissions). HCA are able to exercise market power through having a large share of specialisms in which average cost per treatment (admission) is extremely high. Examining only admissions data will incorrectly rank the importance of facilities. [redacted]
- ii. Market share and market size analysis must be conducted at a specialism level. As shown in Figure 7, market shares within key specialisms are often very substantially higher than the aggregate share. The list of specialisms considered must also be expanded beyond the 17 the CC has focussed on in the PFs to include critical specialisms like [redacted]. As shown in Appendix A of BHF's AIS response the profile of spend in central London is different to that in the rest of the country (where the 17 specialisms may be somewhat more representative).
- iii. [redacted]. Therefore, the CC's assessment must be forward-looking, making sure that competition continues to thrive in central London post the divestments.
- iv. The CC must assess the spare capacity and room for expansion available in the divested facilities. If the divested facilities are significantly capacity constrained then they may not be able to act as effective competitors to HCA facilities.
- v. The CC should assess the cost and profitability of the divested facilities. A 'high cost' facility may be a weaker competitor, and so will not be able to lower prices effectively post divestment. It is BHF's understanding, for example, that [redacted] and [redacted] are 'high cost' hospitals and so will be more restricted in how they can compete with lower prices while remaining profitable.

(b) Are there suitable purchasers available with the appropriate expertise, commitment and financial resources to operate and develop the divestiture business as an effective competitor without creating further competition concerns? Would the remedy be effective only if the entire package were divested to a single owner or would ownership of the divested business by two or more purchasers address the AEC effectively?

4.101 BHF are of the view that, given the commercial attractiveness of central London, there will be strong interest from investors in acquiring the divested facilities. Potentially purchasers include Circle, Aspen, private equity groups and overseas hospital groups looking to enter the UK market. As noted above, while the other national hospital groups will likely be interested in acquiring the facilities, buying key facilities like [redacted] and [redacted] would only augment the group's existing market power.

4.102 BHF does not believe that the effectiveness of the package depends on a single purchaser acquiring all the divested facilities. These are large hospitals that can run on a standalone basis (for example, other standalone hospitals in London include the Cromwell, St Anthony's, St John's and St Elizabeth's and The London Clinic). Therefore, BHF believes they should be sold to at least two separate acquirers. This would have the benefit of significantly increasing the number of rival fascia in central London. Further, selling all divested hospitals to a single acquirer may simply transfer market power in some specialisms to the new owner.

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

4.103 On their own, divestments are not sufficient to address the strength of HCA's position in central London. As set out at paragraph 4.100, a divestiture remedy must be accompanied by a set of behavioural remedies, including measures to ensure that key consultants are not tied to HCA.

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

4.104 The outpatient facilities that feed the main hospital divested should also be part of the divestment package.

4.105 The divestment of [X] should be accompanied by the divestment of [X]. Furthermore, these assets should not be sold to the same buyer. [X]

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

4.106 Given the importance of [X] to corporate PMI customers (because of its size and location), it will retain some market power even outside of HCA's hands. However, were it a standalone facility, insurers would have more options in negotiating with it. Further, in separate hands [X] will become a strong competitor to HCA's other facilities [X] which will significantly improve rivalry across central London [X]

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

4.107 A six month time limit is sufficient.

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

4.108 BHF believes that only these structural remedies, accompanied by the supporting behavioural remedies outlined above, will be effective in remedying the AEC in central London.

4.109 In assessing proportionality, the CC should consider:

- i. The critical importance of the central London market to PMI across the UK due to its disproportionate importance to corporate accounts. If healthcare costs continue to rise unabated in central London, resulting in a tipping point in the corporate market, there will be significant negative fallout for insured customers across the UK.
- ii. HCA's significant excess economic profits earned over the past five years, which appear to be on a sharply increasing trajectory.

- iii. The cost to consumers of not having low-cost PMI network products available in central London.
- iv. Any alleged benefits from economies of scale should be weighed against the evidence that these benefits are not passed through to consumers in the form of lower prices.

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

4.110 No remedies apart from significant divestments, accompanied by the supporting behavioural remedies outlined above, will be effective in addressing the AEC in central London. The central London market has the potential for competition provided sufficient rivalry can be created through the divestments.

4.111 The only alternative to divestments would be a full price control on central London hospitals. However, this would neutralise market forces in a market which has the potential to have very effective competition with strong rivalry (so long as the HCA stranglehold can be reduced materially).

PART 3: REMEDIES TO ADDRESS CONCENTRATION OUTSIDE LONDON

4.112 BHF welcomes the CC's finding of an AEC in local markets outside of central London with respect to insured patients. This is caused by insufficient competitive constraints on BMI and Spire's facilities in certain local areas. Further, we note that the hospitals of concern owned by Nuffield and Ramsay should also be included in this assessment as they face insufficient constraints.

4.113 In an attempt to address this AEC, the CC is considering a package of divestments of BMI and Spire facilities in certain cluster markets. BHF believes that in principle divestments should be effective in increasing competition within cluster markets. [§<]

4.114 We set out our further thoughts on the proposed cluster market divestments as part of our response to the consultation questions below.

CONSULTATION QUESTIONS

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

4.115 A divestiture remedy alone, particularly of the nature proposed by the CC, will not address the AEC outside central London, either effectively or comprehensively. Divestments in cluster markets, if sold to appropriate buyers, should be effective in addressing *some* of the lack of competition in these local markets. However, they will do nothing to address the market power generated by hospital operators in Single and Duopoly markets.

4.116 With regard to the appropriateness of the criteria used to specify the divestment package, consistent with our response to the equivalent question in the central London section, we assume that the CC is referring to paragraph 19 of the Appendix of the Remedies Notice. The five main factors listed in this paragraph are each sensible for specifying the divestiture package of hospitals within cluster markets. However, a number of additional criteria must be added - see paragraph 4.101 for details. Note also that some of the large hospital groups outside central London use Opco-Propco financing structures and these must be taken into account in the design of the divestment package.

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

4.117 There are a range of suitable purchasers for any hospitals within clusters that are divested.

4.118 BHF are of the view that divestments of key Single and Asymmetric duopoly hospitals are also required to address the AEC outside central London. Given that any purchaser of these facilities will automatically inherit a degree a local market power, stricter criteria would need to be applied to potential buyers of these facilities. If such divestments were to be purchased by BMI or Spire, for example, these operators could leverage the facilities to increase national prices through tying or bundling practices. Smaller hospital groups, such as Aspen or Circle, or

independent operators are more appropriate buyers of facilities in Single or Asymmetric duopoly market positions.

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

4.119 Cluster divestments are insufficient on their own to address the AEC outside central London. Within cluster markets divestments will improve competition, although this is unlikely to be a transformational change (given the cluster markets may remain highly concentrated). However, additional remedies are required to address the AEC in Single and Duopoly markets.

4.120 As outlined above, divestments also need to be accompanied by behavioural remedies.

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

4.121 BHF will comment in detail on this in the separate paper.

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

4.122 BHF will comment separately on the CC's specific proposed divestments and their potential impact on local market power. We note, however, that rather than excluding certain assets from the sale it would be better to exclude certain potential acquirers (i.e. the other large national hospital groups).

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

4.123 A six month period should be sufficient in our experience.

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

4.124 In terms of assessing proportionality, the CC must consider that consumer detriment is substantial and appears to be on an increasing trajectory.

4.125 The CC should also consider that cluster hospitals only make up a small proportion of the [§<] hospitals of concern it has identified. Undertaking remedial action to address, in particular, the hospitals in Single and Asymmetric duopoly markets within the hospitals of concern is critical to addressing effectively the AEC outside central London.

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

4.126 Structural remedies are a critical component of any remedy package aimed at addressing the AEC outside central London. Any approach that does not include hospital divestments will not be effective in remedying the AEC.

PART 4: REMEDY TO ADDRESS RISK OF TYING

- 4.127 Large hospital groups leverage the power of their scale and ‘hospitals of concern’ in their negotiations with insurers. This leads to higher prices for insured patients.
- 4.128 A potential way to mitigate this is to stop hospital groups tying together their hospital groups in negotiations. This is imperfect because the hospital operator still has the opportunity to charge excessive prices in the ‘must have’ markets. So the AEC and detriment for insured customers in these markets will not be resolved without the divestments and other measures we have called for above. Given it is a behavioural remedy there is also the need for continued monitoring to limit the dominant hospital groups finding ways around the remedy.
- 4.129 The CC proposes two potential remedies to stop tying. We comment in detail on each below. However, BHF is concerned that currently the proposed remedies to prevent tying have high risks of circumvention and unintended consequences. They will, therefore, be insufficient to address the AEC and the detriment caused by it. They do not rebalance the bargaining position between insurers and hospital groups in the fundamental way that is necessary.
- 4.130 If the CC cannot satisfy itself that a behavioural remedy to address tying is effective (for smaller insurers in particular) then the CC must consider more interventionist measures e.g. more far-reaching divestments.

Ramsay and Nuffield

- 4.131 Before discussing the CC’s proposed remedies BHF notes that it sees no reason why these remedies are confined only to BMI, HCA and Spire. Nuffield and Ramsay also have significant strength from owning ‘hospitals of concern’. Table 2 above (page 20) showed that:
- i. [redacted]
 - ii. [redacted]
- 4.132 Therefore, BHF sees no reason why remedies to address the risk of tying should not be binding on all the main hospital groups – BMI, Spire, HCA, Nuffield and Ramsay.

THE CC’S REMEDY 2(A)

- 4.133 The CC’s “Remedy 2(a)” would prevent BMI, HCA or Spire from raising prices nationally if a PMI changed its network policy (e.g. delists a facility) such that patient volumes were likely to fall. The CC explains that this remedy would seek to limit the ability of groups to exercise market power through the threat of a price increase at facilities the insurers is obliged to continue to use.
- 4.134 The threat from a hospital group to raise prices at ‘must have’ facilities to punish an insurer into taking most (or all) facilities is significant and has been used often. Clearly, restricting the use of this threat is welcome. However, BHF does not believe Remedy 2(a) will be sufficient or effective in constraining the hospital group’s market power. It is too easy to circumvent. And there are significant risks of unintended negative consequences.
- 4.135 The risks of circumvention include:

- i. As the CC itself acknowledges the hospital group may simply structure a volume discount schedule with the insurer at the point of contract negotiation that adds significant cost to the insurer if volumes fall. This will not appear to be the hospital group *'reacting aggressively in the moment'* to a fall in volume by raising prices – as the schedule will appear to have been mutually, *'willingly'* agreed in advance – however its effect will be the same.
- ii. Price rises are not the only way hospital groups can inflict cost on the insurer. Other means include:
 - [X]
 - [X]
 - [X]
 - [X]
 - [X]
- iii. [X]

4.136 Of further concern would be the unintended consequences of the remedy:

- i. In principle, volume discounts are efficient and should not be discouraged; it is when the discount steps in the schedule are not objectively cost-justified that they become problematic. Hospitals may have a weaker incentive to offer volume discounts in the first place if they are locked into the price no matter what happens on volume.
- ii. Even with the remedy, the hospital groups remain in a position to refuse to participate in any new low cost network products launched by insurers. These networks will not get off the drawing board if hospitals in the Single markets refuse to participate. Without these low cost networks the insurer will be unable to attract new customers to the market.

4.137 Any price rise in an out of contract period will need to be reviewed by the CMA (or designated adjudicator). It could take some time before the CMA can establish the price increase was punitive (and not objectively justified) which will create uncertainty.

CONSULTATION QUESTIONS

(a) Would this remedy be effective? Would hospital operators be able to deter PMIs from removing hospitals from their network or recognizing a local rival in ways other than by raising or threatening to raise prices in response?

4.138 This remedy will not be effective.

4.139 Hospital groups have other ways of placing pressure on an insurer not to delist facilities – see paragraph 4.136 above.

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

4.140 Were the CC to determine this remedy was effective – although to be clear BHF does not believe it can be – then there would be no reason why it should not come into effect immediately.

4.141 As noted in paragraphs 4.61, BHF believes the CC should give insurers the option to renegotiate any of their contracts with hospital operators once the remedies are in place, as the nature of relationship between the insurers and hospital group will have changed. It would be inappropriate to burden insured customers for any longer than necessary with the higher prices that were due to hospital group market power.

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

4.142 BHF does believe this remedy is reasonable in that it would help to limit the ability of hospital groups to threaten price increases to force insurers to include all facilities.

4.143 We expect that the significant majority of the cost savings associated with volume take place within each individual hospital rather than at the group level (across hospitals). Therefore, we believe there are stronger grounds to link volume and price within a hospital than at a hospital portfolio level (as is done today).

4.144 Within an individual hospital, BHF recognises that the high fixed cost nature of hospital services means that volume will influence the hospitals unit costs and so will impact prices. BHF believes an insurer that brings greater volumes to the hospital should share in some of the resulting cost savings for the hospital through lower prices. Therefore, volume discounts are efficient; they are not *per se* unreasonable. BHF recognises that if an insurer's volume falls substantially, it may be necessary for the hospital to change its pricing at the affected hospital.

4.145 BHF has concerns where the price increase resulting from a reduction in volume:

- i. Fails to bear any objective relationship to cost and can be so high as to be punitive³⁷.
- ii. Affects the insurer's whole national volumes with the hospital group rather than just the facilities in which volume has fallen.

4.146 There may be some economic rationale for across hospitals volume discounts but we believe these to be minor. Benefits that may arise from scale across multiple hospital sites could include: procurement efficiencies (buying on behalf of many hospitals); shared central IT infrastructure; and, centralised senior management. These are unlikely to account for a significant portion of cost within the hospital group. Further, in practice we note that patients have not seen any of these alleged cross-operator efficiencies – as the PFs show, the largest groups systematically charge the highest prices.

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

³⁷ [37]

4.147 Were the CC to determine this remedy was effective and so implement it, then BHF believes that an adjudicator would be essential to opine on disputes between insurers and hospital groups.

4.148 The CMA may be a competent authority to play this role as monitor and adjudicator. However, BHF believes that a dedicated, standing private healthcare adjudicator should be put in place given:

- i. the specialist knowledge of hospital/insurer pricing and negotiation required;
- ii. the need for the adjudicator to move very swiftly during live hospital/insurer negotiations to determine whether a hospital group's conduct was compliant with the remedy; and
- iii. the potential that a number of requests may be triggered annually as insurers vary network composition.

4.149 The adjudicator's standing position and general overheads should be funded by the main hospital groups. The costs of specific investigations should be borne by the two parties to that dispute, with costs awarded against the hospital group if it is found in breach of the remedy.

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

4.150 As noted above, this remedy can be circumvented in a number of ways and would not be effective on its own.

THE CC'S REMEDY 2(B)

4.151 The CC's "Remedy 2(b)" would require BMI, HCA and Spire to offer and price the hospitals in the portfolios separately (rather than as a bloc)³⁸. This would encourage lower prices in local markets where they face competition. However, in markets where they face little competition they could raise prices.

4.152 The CC raises potential concerns about the practicability of having to negotiate prices on an individual hospital basis (particularly for BMI and Spire given their larger portfolios). The CC explains that it needs to be confident that the negotiation costs involved in separately pricing each hospital would not render the process unviable.

4.153 BHF would welcome hospital groups being required to present individual prices for individual hospitals should the insurer request it (i.e. at the option of the insurer). There are clear advantages to hospitals being presented and priced separately:

- i. The insurer is given the choice (a choice that does not exist today) of which hospitals within the group's portfolio to work with and on what terms. It may be that the insurer chooses to work with all of them, even at a single national price, but this would be at the insurer's choice rather than being forced to do this by hospital group presenting only one 'all or nothing' option.

³⁸ We see no reason why this remedy would not also apply to Nuffield and Ramsay.

- ii. Greater scrutiny would be possible of the cross-subsidisation that occurs between the hospitals within the group's portfolio.
- iii. Pricing may start to reflect local competition, costs and quality.

4.154 However, there are also a number of significant concerns:

- i. [X]
- ii. [X]
- iii. [X]

4.155 In BHF's view, this remedy is not sufficient to address the AEC or to resolve the detriment.

CONSULTATION QUESTIONS

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

4.156 BHF believes it is practicable for hospital groups to provide prices on an individual hospital basis. It may require hospital groups to invest in better understanding and presentation of costs at a service line basis for each hospital in its group. This would be proportionate and, in fact, is information one would expect in a well-functioning market where there was cost-reflective pricing and a focus on efficiency.

4.157 BHF considers that it would be sustainable for it to negotiate on this basis and would indeed welcome it.

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

4.158 Insurers must be given the option to renegotiate all existing hospital contracts with the large hospital groups as soon as possible. There would be no benefit to customers for there to be a wait until the existing contracts come to an end.

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

4.159 As noted, Remedy 2(b) is helpful but not sufficient on its own and so would not be effective on its own. It would need supporting remedies – see paragraph 4.40.

4.160 BHF believes there is a significant risk that prices could rise in 'must have' areas and that entry barriers and the threat of competition law will offer only weak deterrence. Therefore, the CC should not rely on reputational risk to constrain pricing in Single hospital areas.

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

4.161 BHF accepts that the higher prices in Single markets may provide a better signal to new entrants, but given the very high barriers to entry identified in the PFs, BHF is not at all

confident that new entry would emerge at sufficient scale or pace to constrain the pricing in Single hospital areas (particularly if the PH market continues to stagnate).

4.162 There is also significant risk that if there is sufficient scope for new entry into a local market the local incumbent may itself expand to fill this gap. The CC saw this in case study it conducted about entry barriers in Edinburgh, where the incumbent (Spire) took the opportunity to expand its presence so as to protect against a new entrant.

4.163 BHF, therefore, considers it necessary to reduce the power of the groups' Single and Asymmetric duopoly hospitals through the measures detailed above (section starting at 4.41).

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

4.164 There is a risk that some inefficient hospitals may close if the tying is stopped. However, this is in the interests of the sector. Currently there is surplus capacity and inefficient business models. Market forces are being prevented from forcing efficiency or rationalisation. Stripping out this inefficiency will make private healthcare more affordable over the longer term.

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

4.165 Yes, BHF believes that hospital operators could frustrate the remedy in a number of ways.

4.166 As the CC notes, if hospitals are able to continue to use consultant incentive schemes, the insurer's options will be constrained even in markets where there are alternative facilities. Therefore, consultant incentive schemes would need to be banned.

4.167 The CC would need to nullify any contractual clauses applied by hospital operators to limit the insurer's ability to move volumes between different hospitals.

4.168 [§<]

PART 5: RESTRICTION ON PPU EXPANSION

4.169 The CC's 'Remedy 3' considers that incumbent hospital operators within Single or Duopoly areas should be prevented from expanding through partnerships with NHS PPUs in that local market. The CC believes that this "*may mitigate the AEC in Single or Duopoly areas*" because if a NHS PPU does choose to enter/expand it will then increase rivalry rather than be captured by the incumbent.

4.170 BHF welcomes this remedy. However, we note the following:

- i. The remedy addresses only the risk of further concentration of these already highly concentrated markets, rather than addressing any of the existing concentration. Today's weak competition in these local markets will continue until the PPU enters and reaches sufficient scale. Successful entry on this scale remains uncertain, and the CC cannot 'bank' on emerging competition from PPUs resolving AECs in these local markets either quickly or fully.
- ii. The CC must clearly explain the local areas in which this remedy will apply. As drafted it appears to be constrained to Single/Duopoly areas only. However, it is in central London that BHF has greatest concern about HCA using this tactic of PPU partnership to reinforce its position. This remedy must apply also to central London.
- iii. The owners of affected hospitals must be clearly warned about which current/potential PPUs would fall within their catchment or a clear methodology established that would allow this to be definitively established.

CONSULTATION QUESTIONS

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

4.171 The CC must be clear on what 'effective' means in this context. As noted above, this remedy will have no direct impact on today's AEC or detriment in the Single and Duopoly markets. So it is not effective in remedying existing problems. It would however assist to stop the position in these markets getting even worse.

4.172 BHF cannot say the precise number of Single or Duopoly areas in which PPUs are likely to emerge at sufficient scale to be credible alternatives. However, we do not expect it to be a significant number of local markets. We base this view on our experience that:

- i. PPUs tend to require significant investment. For example, in Annex A of BHF's Original Issues Statement Response we provided patient satisfaction survey feedback that demonstrated that PPUs needed to improve their facilities significantly in order to meet patients' expectations.

- ii. Even where PPU entry occurs, these facilities do not become full-service line competitors but rather focus on a small niche of specialisms³⁹.
- iii. It is our understanding that the policy positions in Scotland and Wales means it is unlikely that PPU entry will take place on significant scale in these regions.

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

4.173 BHF has no reason to believe it would not be practicable. HCA has, for example, taken a strong competitive position through the Christies in Manchester even though it did not operate a hospital in that area.

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

4.174 The loss in choice for the NHS Trust would be very limited; only one potential partner (the local incumbent) would be removed. This loss of choice would not outweigh the significant costs to consumers if an incumbent is able to expand its market power through partnering with the local PPU. Further, the reason the incumbent has historically been able to outbid other interested parties for the PPU is because it was securing its market power and the superior financial returns which the position allowed. Therefore, the benefit received by the NHS Trust from the higher price was, in part, because of market power.

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

4.175 It seems highly unlikely there would be any material detriment. If the market is sufficiently attractive and in need of additional capacity, then it seems likely that another hospital operator would be interested in the PPU or that the NHS Trust's own management could run the PPU.

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

4.176 As noted above, there needs to be clear publication of the hospitals that would be restricted from partnering with PPUs. If that is achieved we would not expect this remedy to require significant monitoring. Insurers and the public could draw the attention of the CMA (or another designated enforcer) to any potential breach.

³⁹ Appendix 3 of BHF's Annotated Issues Statement response showed that PPUs tended to be small and focussed on only a subset of specialisms.

5. ADDRESSING CLINICIAN INCENTIVE SCHEMES

- 5.1 In this section, BHF comments on the CC's proposed remedy to address the AEC resulting from consultant incentive schemes.
- 5.2 The CC proposes “[p]reventing hospital operators from offering consultants any incentives, in cash or kind which are intended to or have the effect of encouraging consultants to refer patients to or treat them at its hospitals except where such ownership results in a reduction in the barriers to entry that is likely to be at least as beneficial to competition as any distortion is harmful”⁴⁰.
- 5.3 BHF agrees with the CC that incentive arrangements between private hospital operators and consultants are a feature of the private healthcare market that give rise to an adverse effect on competition. BHF agrees with the need to remove all such arrangements (whether they are short-term or long-term).
- 5.4 BHF believes that the most clear-cut and effective remedy would be to prohibit all incentive arrangements between consultants and private hospitals / hospital operators. Should however the CC decide that an exemption in favour of certain equity participation schemes is required (in order to encourage new entry in local markets), BHF's view is that the way in which this exemption should operate must be fair and clear, and subject to full disclosure (see paragraphs 5.14 to 5.16 below).
- 5.5 BHF accepts that there is a case for exempting from any prohibition the provision of certain services and / or facilities by hospitals or hospital operators to consultants where these are provided at full market rates, provided that there is full disclosure of these arrangements and such exemption is strictly controlled (see paragraph 5.17 below). BHF would also recognise a case for a very limited *de minimis* exemption for arrangements which are below a particular financial threshold (see paragraph 5.18 below), in order to avoid uncertainty at the margins as to whether a low value benefit was caught by the prohibition.
- 5.6 If the CC is minded to introduce an exemption in respect of particular types of incentive arrangement, BHF's view is that there should be an obligation on both hospital operators and private consultants to disclose publicly the details of these arrangements. They should be time-limited i.e. expiring after a period following entry. This additional transparency would allow any non-exempted arrangements to be reported by other doctors, hospitals, patients or insurers and, if necessary, investigated and sanctioned by the GMC; there should likewise be penalties for hospital operators, hospitals and consultants who have entered into incentive arrangements in breach of any CC remedy relating to consultant incentive arrangements.
- 5.7 Taking the specific questions raised by the CC in its Remedies Notice in turn, BHF sets out below its views on the CC's suggested remedy in relation to consultant incentive arrangements.

⁴⁰ Paragraph 60, CC Remedies Notice, 28 August 2013

CONSULTATION QUESTIONS

Is the remedy practicable?

- 5.8 BHF believes that the proposed prohibition on incentive arrangements is practicable, and can be implemented within a reasonable time period. It may be necessary to allow a period for existing incentive arrangements to be unwound or re-valued on fair market terms, but new agreements could be stopped with immediate effect.
- 5.9 In order to be effective, any prohibition needs to be supported by the availability to the GMC of clear sanctions for breach of the prohibition (whether intentional or otherwise). For example, Bupa notes the precedent under the Physician Payments Sunshine Act and the Stark Law (both in the US), under which organisations and individuals can be fined for failures to disclose the details of incentive arrangements or for entering into prohibited incentive arrangements.
- 5.10 BHF agrees with the CC that simply amending current incentive arrangements (so as to introduce, for example, provisions obliging consultant compliance with GMC guidance) would be insufficient to address the adverse effect on competition that has provisionally been identified. Such incentive arrangements have a *per se* distortive effect on the private healthcare market, and simply altering or adding certain terms to these arrangements cannot provide a clear-cut and effective remedy. Indeed, the obligation to comply with GMC guidance already exists but has not prevented incentive schemes from operating in a distortive manner⁴¹. Moreover, BHF believes that it would be very difficult to make an *ex post* assessment as to whether or not a particular referral had been materially influenced by an incentive scheme to which a consultant was a party.
- 5.11 For these reasons, BHF therefore agrees with the CC that private hospitals / hospital operators should be precluded from entering into any type of incentive arrangement with consultants.
- 5.12 The CC identifies three categories of consultant incentive arrangement in its remedies notice:
- I. Short-term incentive arrangements, such as fee for referral schemes or annual payments for practising at the hospital. Such incentive schemes have a clear tying effect which distorts competition. Such incentives can also cause patient harm.
 - II. Longer-term incentive arrangements, such as equity share arrangements. Such schemes may be less immediately harmful to competition (in the sense that any economic benefits accruing to a consultant are likely to be delayed and may be smaller in size than those received under short-term incentive arrangements). However, as the CC has provisionally recognised, they distort the competitive dynamics of the private healthcare market by, for example, blocking new hospital entry into local markets.
 - III. Certain equity share arrangements which, in the CC's view, may be at least as beneficial as the distortions to competition that they create - by reducing, for example, barriers to entry and encouraging new hospital entry.
- 5.13 BHF agrees with the CC's conclusion that, in relation to the short-term and long-term incentive arrangements under (I) and (II) above: (a) such arrangements should be prohibited and (b)

⁴¹ The GMC's Good Medical Practice Code already proscribes dealings which may affect a doctor's ability to deal fairly with their patients – see, for example, clauses 77 to 80 of this Code.

there should be no difference in the type or nature of the prohibition of such incentive arrangements.

5.14 In relation to paragraph 5.12 (III) above, the CC has provisionally recognised that consultant participation in the equity of new hospitals can lower barriers to entry and has therefore proposed that such schemes be exempt from any general prohibition on consultant incentive arrangements. However, BHF does not believe that it is practicable to identify clearly those equity participation schemes that are likely to be at least as beneficial to competition as any distortion is harmful. Consequently, an attempt to draw such a line between different schemes is likely to create inconsistencies and complexity, at the expense of clarity⁴². For example:

- "New entry" would need to be defined. Would an exemption apply where an existing hospital in a particular local market wanted to expand into a new specialism and, if so, how would a new specialism be distinguished from an expansion?
- The time period over which the exemption would be available would need to be determined. We assume that any such exemption would be time-limited and only available for so long as it was incentivising entry. Should this be determined in terms of a firm time limit? Or should there be some kind of measure of hospital viability before an incentive scheme ceases to be permitted (so as to ensure that any beneficial effects on the competitive structure of the market as a result of an equity participation scheme are maintained)?
- The mechanism through which any potentially exempt equity participation scheme would be assessed (in terms of its likely pro- and anti-competitive effects) would need to be very tightly drawn.

What framework of rules could be used to determine reasonably and practically whether the benefits of an incentive scheme in terms of lowering barriers to entry, outweighed the distortions created? What degree of oversight would be required to monitor compliance and who should fund it and exercise monitoring?

5.15 In addition to the question of whether exempting certain equity participation schemes is practicable (see paragraph 5.14 above), BHF also maintains that such an exemption is not necessary or desirable. It is not necessary because if incentive schemes between *incumbent* providers and consultants are prohibited in any event, consultants would necessarily be free to refer patients to the entrant and there would be a much lower risk of consultants being tied to incumbent hospitals. This in itself will lower barriers to entry which is the main justification for using these schemes. Exempting such schemes is not desirable because (as noted above) the GMC already has guidelines in place which seek to prohibit consultants (and other medical professionals) from having interests which affect the way in which they refer patients. BHF's view is that it would be perverse for the CC to sanction behaviour (the entering into of certain equity participation schemes) that may breach GMC guidelines.

5.16 BHF therefore does not agree that different arrangements should apply to particular types of equity participation schemes. However, were the CC nonetheless to be minded to introduce an

⁴² For the avoidance of doubt, BHF restricts its response in relation to equity participation schemes to such schemes as they relate to hospitals providing inpatient care and does not take issue, in the context of this response, with consultants participating in the equity of consultant clinics.

exemption in respect of certain equity participation schemes, BHF believes that the exemption needs:

- i. To be defined on a clear and transparent basis (i.e. by reference to objective criteria and therefore capable of verification). This means that individual exemptions should not be defined on an ad hoc, case-by-case basis, but instead subject to objective, pre-agreed criteria; and
- ii. To be fully disclosed. Specifically, any hospital operator making use of the exemption should be required to disclose (including disclosure of all shareholdings) fully such use to insured and self-pay customers, the GMC and insurers (and other commissioners of care)⁴³.

How could a 'fair market price' test be monitored and enforced and who would be responsible for doing so?

5.17 BHF recognises that there may be a case for distinguishing arrangements between hospitals and consultants under which services are provided at market value. BHF's view is that where hospital operators offer consultants the use of certain facilities at fair market value ("**Exempt Facilities**") this is not objectionable provided that the terms on which such facilities are offered do not themselves create a tying effect. Specifically:

- i. Exempt Facilities arrangements would need to be clearly and exhaustively identified and disclosed publicly (for example, on the relevant hospital or hospital operator's website).
- ii. Exempt facilities should not be available under terms which would themselves have a tying effect. For example, if the duration of any contract under which facilities were offered was particularly long-term (for example, longer than one year), with no option for the consultant to terminate early without penalty, the very duration of the contract would have a de facto tying effect between the hospital operator supplying the facility and the consultant benefitting from it, to the clear detriment of other hospitals / hospital operators in the relevant local market.
- iii. BHF notes the definition of fair market value in the US under the Stark Law, and sees some merit in the CC considering a similar approach⁴⁴.

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

⁴³ BHF also notes the reporting requirements in the US under the Stark Law and the Physician Payment Sunshine Act, both of which impose a reporting requirement in respect of physician shareholdings and other ownership or investment interests in certain prescribed entities (such as hospitals).

⁴⁴ Fair market value, for the purpose of the Stark Law is defined as "*the value in arms length transactions, consistent with the general market value, and, with respect to rentals or leases, the value of rental property for general commercial purposes (not taking into account its intended use) and, in the case of a lease of space, not adjusted to reflect the additional value the prospective lessee or lessor would attribute to the proximity or convenience to the lessor where the lessor is a potential source of patient referrals to the lessee*". BHF also notes that the Stark Law ensures that rates charged to physicians (for example, for the rent of consulting rooms) are not tied to any referrals that the consultant makes to a hospital operator or particular hospital. Guidance on the application of the Stark Law notes that "*nothing precludes the parties from calculating fair market value using any commercially reasonable methodology that is appropriate under the circumstances*". BHF sees some merit in such an approach, which places an initial burden of deciding a fair market value on the contracting parties themselves (both hospital operators and consultants), so long as purportedly fair market value transactions are also monitored by an appropriate third party.

- 5.18 In the interests of proportionality, BHF would also accept that benefits below a particular financial threshold (for example, social events, promotional stationary, facilities for training events) may not sufficiently affect consultant behaviour (in particular referral patterns) to warrant prohibition. BHF also recognises that such a *de minimis* exception may also help to mitigate any uncertainty as to what, in marginal cases, may or may not be a prohibited incentive. Therefore, while BHF believes that the simplest approach is to prohibit incentive arrangements outright, it would also be willing to accept a very limited *de minimis* threshold to cover these types of situation (which would need to be set at a low level – [§<]per consultant per annum would be an indicative example of the level of such a threshold)⁴⁵.
- 5.19 BHF does not believe that any other exemptions should be considered by the CC. Introducing a range of exemptions to any general prohibition is likely to prove confusing and may jeopardise the remedy's effectiveness and clarity.

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

- 5.20 Given the anti-competitive effects that the CC has found arising from of incentive arrangements, BHF does not believe it desirable for existing incentive arrangements to be 'grandfathered': were current arrangements to continue in force, this would clearly maintain the barriers preventing new hospitals entering local markets. BHF's view is that current incentive arrangements falling within any prohibition should be unwound within 6 months.

Is the remedy comprehensive? Should it apply to other healthcare service providers such as laboratories or firms supplying diagnostic services such as imaging, for example? Should PMIs be permitted to operate incentive schemes which reward consultants who recommend cheaper treatments or less expensive hospitals?

- 5.21 As noted, BHF believes that, in principle, all incentive arrangements that have the effect of biasing a consultant's referral behaviour by incentivising referrals to particular hospitals or hospital operators should be prohibited. As the CC is aware, BHF believes that it is part of the role of a PMI provider to give its customers advice and recommendations as to which hospital to use, taking into account hospital quality and treatments, value for money and customer policy requirements. However, BHF does not (and is not aware that any other PMI that does) engage in arrangements with consultants that would influence consultants' ability to make unbiased referral decisions to their patients.
- 5.22 In relation to incentives paid to consultants by other healthcare providers, such as laboratories or medical device providers, BHF believes that such incentives should be prohibited where they affect referral patterns⁴⁶.

⁴⁵ BHF notes the precedent under the Physician Payment Sunshine Act, which requires pharmaceutical, biological and other medical suppliers to disclose to the US health authorities any payments above \$10 made by such suppliers to physicians or teaching hospitals. This threshold demonstrates that the US authorities view even very small payments as having the ability to influence referral patterns. BHF also notes a US study which illustrates that similarly small incentive payments to physicians from pharmaceutical companies have a material effect on the type of prescriptions that physicians make (see <http://rady.ucsd.edu/faculty/directory/engelberg/pub/portfolios/DOCTORS.pdf>).

⁴⁶ Were hospital operators to partner with other healthcare providers (such as laboratories or medical device providers) so as to evade a prohibition on hospital operators themselves offering incentives directly to consultants (by instead channelling incentive payments indirectly through these other healthcare providers), BHF believes that this behaviour should be included within the

Unintended consequences

- 5.23 BHF recognises that a consequence of a prohibition on incentives is that consultants will have to cover costs that would previously have been absorbed by the hospital. As a result, a consultant's cost base may increase and in turn may lead to increased upward pressure on consultant fees. However, this does not represent an additional cost in the system since these costs are already being passed onto consumers by the hospitals themselves.
- 5.24 BHF is confident that some consultants will be able to absorb through finding operational efficiencies e.g. sharing secretarial support. However, BHF has concerns that this sharing of costs does not result in consultant groups forming that have the effective of reducing patient choice and raising prices (as has been seen in anaesthetics and ophthalmic services).

Are there regulatory regimes in other jurisdictions that the CC could form in the context of remedy specifications and implementation? Would, for example, the Stark Law in the USA be a useful model as regards restrictions on the commercial relationships between healthcare facilities and clinicians and their introduction?

- 5.25 BHF notes the CC's request for an assessment of overseas jurisdictions' controls of incentive arrangements, in particular the Stark Law in the US. BHF believes that the Stark Law has certain aspects which could usefully be employed in any CC remedy, notably in relation to fair market value, the ability to enforce and apply sanctions, and the ability to hold hospitals as well as doctors to account. BHF notes that claims have been brought in the US against private hospital operators for breach of the Stark Act. For example, in 2012 HCA settled (for \$16.5 million) a claim brought against it, in which it was alleged that HCA had entered into financial transactions with physicians in order to induce these physicians to refer patients to HCA facilities. The financial transactions included HCA making rental payments to the physicians at a rate far in excess of fair market value, as well as a release of these physicians from separate lease obligations owed to HCA⁴⁷.

The general prohibition under the Stark Law

- 5.26 Under the Stark Law, where a physician has a financial relationship with an entity providing certain designated health services, a physician is prevented from referring a patient to that entity if such referral would result in a payment to the physician⁴⁸. The onus, under the Stark Law, is on the physician not to make referrals where they are party to a financial relationship with a hospital operator, rather than on hospital operators either not to enter into incentive arrangements with physicians or not to offer such financial incentives to consultants or clinicians in the first instance. As noted, BHF's view is that in the context of the UK market, it is appropriate that an obligation not to enter into incentive arrangements be imposed on hospital operators, since it is these operators which have market power and in respect of whom this remedy is intended.
- 5.27 A second element of the general prohibition under the Stark Law is that an entity providing certain designated health services cannot present a claim to a third party (such as an insurer) for payment of those services if they were referred by a physician in contravention of the Stark

scope of a CC remedy. Indeed, the Stark Law includes a term which expressly penalises entities which engage in this type of behaviour – see s.1877(g)(4) of the Social Security Act.

⁴⁷ See <http://www.justice.gov/opa/pr/2012/September/12-civ-1133.html>.

⁴⁸ s.1877(a)(1) of the Social Security Act. See http://www.ssa.gov/OP_Home/ssact/title18/1877.htm.

Law⁴⁹. BHF's view is that an equivalent obligation, whereby a hospital operator could not bill an insurer for work undertaken as a result of referrals from a consultant who was party to a prohibited incentive arrangement with that hospital operator, should also be considered by the CC as part of any general prohibition on consultant incentive schemes. This it would provide a further layer of protection for insurers (and, ultimately, private healthcare customers).

Disclosure Requirements under the Stark Law

5.28 The Stark Law requires the disclosure of hospitals' ownership, investment and compensation arrangements⁵⁰. Such a disclosure requirement therefore covers a holding in shares or debt in a hospital operator or a hospital, as well as more straightforward incentive scheme arrangements. BHF believes that this is a comprehensive and straightforward approach to disclosure and should, if the CC is minded to allow certain types of incentive scheme to continue, be applied in respect of any CC remedy.

Enforcement

5.29 Under the Stark Law, the Secretary of Health and Human Services is responsible for the enforcement of the law's relevant compliance and reporting requirements. Sanctions for breach of the Stark Law include fines for failure to report details of a hospital's incentive or other financial arrangements (up to \$10,000 for each day for which a report should have, but was not, made) and fines for presenting claims for services which have been provided as a result of a prohibited referral (up to \$15,000 for each service). As noted earlier, there have also been substantial claims made for breach of the Stark Law in the civil courts.

⁴⁹ Ibid.

⁵⁰ S.1877(f) of the Social Security Act.

6. ADDRESSING INFORMATION AVAILABILITY

6.1 The PFs make clear the significant deficiencies in the information made available by hospitals and consultants.

6.2 In brief:

- i. There is an absence of published information on consultant quality.
- ii. There is a lack of comparable information on consultant fees. This makes it difficult for patients to shop around.
- iii. There is a lack of information on hospital quality. Private hospitals lag the NHS in information provision. Recent actions by industry (e.g. through PHIN) have been inadequate in addressing this.

6.3 The investigation has further revealed:

- i. It is very difficult to compare/benchmark prices between hospital operators because of the complexity of their coding and pricing structures, with only a small proportion of treatments being on common codes.
- ii. There is no transparency on hospitals' underlying costs of services. Prices for services are set at a national level based on a financial envelope rather than based on service costs.
- iii. Few private hospitals contribute information on private patients to Hospital Episode Statistics (HES).
- iv. There is a lack of disclosure from consultants on participation in consultant groups. The size of such groups limits patient choice and presents opportunities to overcharge patients.
- v. There is no central authority taking responsibility for compiling, auditing and publishing information in private healthcare.
- vi. There is a clear desire from patients/GPs/insurers for more and better information. For example, the CC's GP Survey found that 86% of GPs felt that they did not have sufficient information on at least one factor to help them identify the most appropriate consultant.

6.4 The scale of the problem is large, endemic, and entrenched. The combined effect of these features is to create adverse effects on competition and patient safety. Many providers benefit directly from the softened choice and competition created by the absence of relevant information. So there will, of course, be significant resistance to any change to the status quo. Further, for all providers, improving information provision will take commitment and resources, meaning an immediate impact on their bottom-line; although for the providers who deliver best quality and value for money this impact will be positive in the long term.

6.5 However, these cost concerns are trivial in comparison to the significant consumer benefits that will arise from improved information. The benefits to patients and customers will be both clinical and financial:

- i. Good information on clinical quality and outcomes promotes and protects **patient safety**. It encourages providers to consider quality more seriously. Dangerous clinical practices or providers are identified and can be addressed.
- ii. It allows **improved decision making** by patients and improved confidence that the decisions made *'put the patient first'*.
- iii. Commissioners of care (e.g. insurers) can benchmark provider performance. Comparison facilitates competition and so improves quality and **value for money**.
- iv. Providers can **strive for efficiency** and better outcomes through benchmarking themselves against the industry (on cost, quality and other metrics). Stripping out inefficiency keeps PH affordable.
- v. Improved datasets and information availability **reduce transaction costs** in commissioning care and reimbursing providers.
- vi. Good information encourages insurers and other organisations (e.g. Dr Foster) to **compete on quality and information provided** on private healthcare for consumers.
- vii. Commissioners can move towards **outcomes-based reimbursement**, which rewards the providers and innovators that have most beneficial impacts on patients.

6.6 The CC is, therefore, in a unique position to make much needed and long overdue transformational change to the provision of information in the sector, change that cannot take place without external intervention.

6.7 It is on the basis of this significant opportunity that BHF is, therefore, concerned that the CC's proposals in the Remedies Notice in relation to information do not address some fundamental problems in the market. As a consequence, some of the proposed remedies will not be effective in removing the AECs relating to information. As a package they are not sufficient. The remedies provide some welcome progress in places, but need to go significantly further to make meaningful improvement.

6.8 The section is structured as follows:

- Part 1 sets out the general principles that BHF believes the CC should apply in considering the remedies related to information.
- In Part 2:
 - a. We briefly comment on the CC's proposed information remedies and offer recommendations to strengthen each remedy.
 - b. We then explain the additional remedies BHF believes are necessary and proportionate to address the AEC.
 - c. Finally, we respond to the CC's detailed consultation questions on its remedies.

- Annex A presents BHF's detailed framework of a well-functioning information system in the PH sector.
- Annex B presents a list of safety and clinical quality metrics that BHF collects from providers.

PART 1: GENERAL PRINCIPLES FOR INFORMATION REMEDIES

6.9 The key focus must be to improve decision-making, safety, outcomes and value for money for patients. The patient must come first. However, one must recognise that patients are not the only users or in many cases even the main user of information in achieving these goals. Other relevant users include:

- Regulatory bodies (e.g. CQC and GMC) that protect patient safety by monitoring the quality of providers and taking action against providers where needed.
- Commissioners of care (e.g. insurers) who are relied upon by patients to analyse information and achieve higher quality and value for money on their behalf.
- GPs who are relied upon by patients to assist in making informed choices.
- Providers who will have an interest in understanding their relative performance, strengths, and weaknesses.
- Intermediaries such as Dr Foster that help patients and commissioners make better informed decisions.

6.10 These different groups require different information in terms of complexity, granularity and format. For example, commissioners of care need data in a format that can be aggregated into databases to allow batch benchmarking across providers, with sufficient granularity and information to control for factors such as case mix. Patients themselves, on the other hand, may want data pre-packaged in a form or metric that is easily understandable and actionable to someone without clinical knowledge. Therefore, BHF would recommend that the CC look at each remedy both from the perspective of improving patient choice directly and from the perspective of the agents that assist the patient in making choices and getting best value for money.

6.11 BHF considers the following key principles must apply in the design of effective and sustainable information remedies:

- i. **The information provided must enable change in the decision making of patients/commissioners of care/providers.** A lack of information prevents effective decision making. However, simply publishing 'more' information is meaningless if that information fails to change the way users make decisions today.
- ii. **The information must improve comparability between providers.** Competition and choice can only be improved if the information published allows patients/GPs/insurers to benchmark and compare the differing levels of performance and price from providers. If the information published does not facilitate comparison of providers it will not meaningfully change decision making.
- iii. **The information must support comparability with the NHS** – care across the NHS and the private sector will become increasingly integrated over time. Hence, comparability

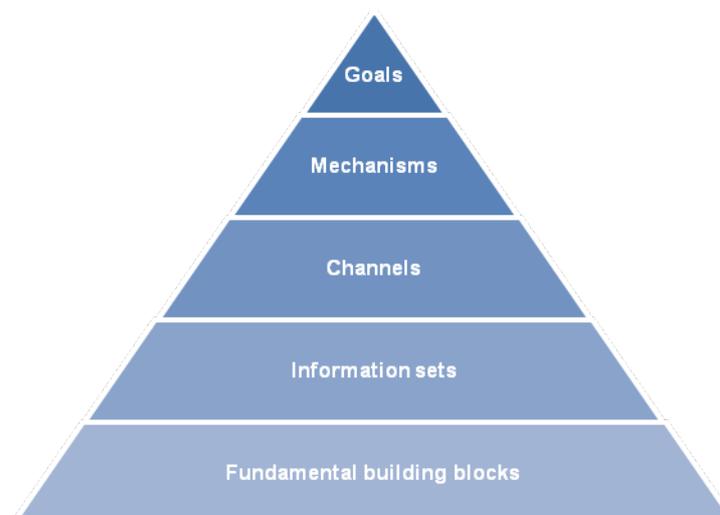
between the two sectors will become more relevant for GPs, patients, and commissioners. This will include matching every private patient with his or her unique NHS identification number. Only then will datasets like HES be useful for making comparisons between the private sector and the NHS. Moreover, matching private patients with their NHS identification number will enable providers to better understand their patient's history and deliver appropriate care.

- iv. The private sector should therefore seek to **achieve and maintain ('future proof') parity with the NHS** in the information available, but in reality should aim to exceed that minimum level.
- v. **It must be mandatory for all private providers to provide the information.** It should be a 'normal course of business' activity for all private providers to publish data that allows informed decision making by commissioners and patients and that promotes patient safety. Comprehensive coverage of providers is essential to comparison. No provider should be excused from disclosing information. A voluntary disclosure system risks a situation where inferior providers choose not to publish information, making it difficult for superior providers to differentiate themselves and get rewarded for their superior service.
- vi. **The information/data must be as flexible as possible.** Healthcare is dynamic, with changing technologies, innovative treatments, and evolving models of delivering care. If the metrics published about quality, for example, are too rigid they may become outdated and irrelevant or may discourage providers from adopting improved treatment practices. Therefore, to maximise flexibility, data should be provided to commissioners of care and intermediaries like Dr Foster in a disaggregated, raw format. This will allow insurers/intermediaries to analyse the data in detail and they can then compete on how the data is used (e.g. the metrics that can be developed) and communicated to patients.
- vii. **The information must be objective.** The data needs to be, or have the option of being, validated by a body independent of the provider to ensure accurate reporting. Therefore, there needs to be audit provisions and sanctions for poor reporting.
- viii. **There must be a clear and committed timetable.** Filling the information gap will take time and will require resources from different stakeholders. A clear timetable of milestones to achieve is needed to ensure that action does indeed take place and parties can be held to account for lack of progress.
- ix. **Better information is only part of a solution.** It will not solve some fundamental issues of entrenched market power. Its impact will be gradual (taking years), whereas the market needs more urgent, targeted change. The issues of local market power of hospitals, the impact of 'one in, all in' negotiation tactics by the hospital groups and consultant incentive schemes need to be tackled directly. If these features are allowed to persist, improved information transparency will have relatively little value to patients.

A well-functioning information system

- 6.12 A well-functioning information system for private healthcare has several layers. To assist the CC in its thinking, Figure 9 illustrates some of the key attributes of a well-functioning information system (**Annex A** details the underlying elements of this framework).

Figure 9: Framework for a well-functioning information system (see Annex A)



- 6.13 At the top of the pyramid are the **key goals** that better information could help patients achieve – the outputs of a well-functioning system. For example, the industry should be able to use the information available to guarantee patient safety and achieve better patient outcomes.
- 6.14 To achieve these outputs, certain **market mechanisms** must take place. For example, patients need to be able to exercise choice over different providers based on performance indicators. Hospitals and consultants need to be able to use the data available to benchmark performance so as to improve efficiency. Commissioners of care need to be able to identify unwarranted treatment variation and inappropriate medical practises. In parallel, a regulatory authority needs to be able to monitor and act upon poor provider conduct.
- 6.15 These mechanisms rely on several data sources and the **channels** through which users can access these relevant information sets. Portals must exist for patients, GPs, commissioners, providers, and intermediaries (e.g. Dr Foster) to access and act on each dataset. A wide spectrum of **information sets** is required to support each participant in the private healthcare sector. For example, clinical quality datasets will help commissioners assess which providers prioritise patient safety. In addition, cost datasets are necessary to enable efficiency benchmarking of hospitals. These datasets need to be bridged such that they can be used side-by-side. Activity and outcome datasets should provide commissioners with information on what treatments a provider is offering and how effective these treatments are.
- 6.16 Finally, these datasets rely on a fabric of data architecture and provider conduct – the **fundamental building blocks** of an information system. For example, a standardised coding structure is needed to enable benchmarking of prices, reduce transactional costs, and ensure that information is collected consistently. Consultants and hospitals should contribute to relevant datasets on a frequent basis. Providers should disclose all conflicts of interest such that patients can make an informed decision. Most importantly, the datasets must at least maintain (future proof) parity with the NHS – each private patient should be matched with his or her unique NHS identification number to not only facilitate better comparisons but also deliver better care.
- 6.17 Currently the CC’s proposed remedies influence only parts of this system, and it is on that basis that BHF believes the CC must strengthen the remedies proposals (see paragraphs 6.19, 6.40, 6.42, 6.59, and 6.60).

PART 2: BHF’S COMMENTS ON THE CC’S PROPOSED REMEDIES

6.18 As noted above, BHF considers that the CC’s proposed remedies provide some welcome steps forward, but must go significantly further if they are to be effective in addressing the AECs.

Table 4 summarises BHF’s views on each of the CC’s proposed remedies. We provide detailed reasoning and responses to the CC’s consultation questions later in this section.

Table 4: Summary of BHF’s comments on CC’s proposed remedies

CC’s proposed remedy	BHF’s comments in brief
<p>“Remedy 5” proposes a recommendation to the health departments of Scotland, Wales and Northern Ireland that they collect and publish consultant performance indicators arising from their NHS practice equivalent to that (to be) published in England, which covers individual consultant data in ten medical specialties.</p>	<p>BHF strongly supports the publication of consultant outcome data. However, in its current form, this proposed remedy is not effective or sufficient and will not change the way patients make decisions today nor will it aid commissioners significantly. Therefore, it is currently ineffective in addressing the AEC in relation to consultant quality.</p> <p>This is because:</p> <ul style="list-style-type: none"> • The NHS England datasets cover only 10 specialisms; over forty specialisms are not covered including major ones such as Oncology. • The NHS England datasets currently cover under 4,000 consultants in the NHS (out of over 30,000 practising in England), offering very limited coverage. • Some of the 10 specialisms present indicators only for one or two procedures. The key ‘outcome’ metric is usually risk-adjusted mortality, which several of the datasets explain should <u>not</u> be used to rank or differentiate between consultants. • The NHS data covers NHS activity only. NHS practice is not always fully comparable to the procedures offered in the private sector, so a private patient will not always get information relevant to his or her own decision. • The remedy shifts all responsibility onto the NHSs (and taxpayers), rather than private providers. The NHS is already strained for resources and has its own significant reform priorities. Therefore, it may mean a significant amount of time before private patients can benefit from any improved information. • The NHS data is not easily accessible for private insurers, making it difficult to use in benchmarking. <p>BHF has proposed an alternative remedy related to clinical registries (see paragraph 6.19).</p>
<p>“Remedy 6” proposes that consultants would be required to provide patients with a list of proposed charges for treatment in writing prior to the commencement of treatment.</p> <p>It would also include all consultants practicing privately to publish the fee for their initial consultation on the web (both on private websites and the websites of the hospitals at which they have practising privileges).</p>	<p>BHF strongly supports a requirement for ALL private consultants to get financial consent <u>in writing</u> before treatment. The GMC has long required transparency of fees from consultants but this recommendation has been widely ignored. In addition, outcome three of the CQC essential standards need to be enforced⁵¹ – the requirements are poorly adhered to and the CQC has never investigated a private provider to BHF’s knowledge. Therefore, the first element of the remedy is welcome. The written information provided should include:</p> <ul style="list-style-type: none"> • Standard wording on the rights of the patient on each written quotation. • Advice to the patient to check eligibility and reimbursement levels with their insurer (rather than the consultant advising on these). • Revised quotations, with written justification, provided in writing whenever cost of treatment is expected to change from that originally quoted. An emergency procedure will need to be clearly defined – there should be a defined process on

⁵¹ <http://www.cqc.org.uk/organisations-we-regulate/registering-first-time/essential-standards> (Date accessed: 20th September 2013).

	<p>how to bill in such circumstances. The AAGBI offers some guidance on this issue⁵². These guidelines should be reviewed, strengthened, and adopted across all specialisms, not just anaesthetics.</p> <ul style="list-style-type: none"> • Where a procedure requires anaesthesia, the lead consultant's quotation must also explain the anaesthetist fees, given there is seldom opportunity for the patient to negotiate or switch at the point of meeting his or her anaesthetist. <p>As part of hospital visits, the CQC should check this requirement is met and use enforcement orders to encourage good medical practice. The GMC should issue clear guidelines to all consultants outlining the gravity of this requirement and consequences from non-compliance.</p> <p>An independent adjudicator (e.g. The Parliamentary and Health Service Ombudsman⁵³ or Trading Standards) must be available and known to patients so that they can rapidly challenge a consultant's fees (e.g. if the consultant charged an unexpected shortfall).</p> <p>The second element of the remedy – the publication on the web of outpatient consultation fees – is more complicated and susceptible to unintended negative consequences. A key challenge is that consultants may have agreed different outpatient consultation fees with different insurers. BHF, therefore, believes this element of the remedy should be replaced with the following provisions:</p> <ul style="list-style-type: none"> • Consultants should be obliged to notify outpatient consultation fees to insurers such that insurers can advise patients of different choices local to the patient; • For self-pay patients, consultants should publish their self-pay outpatient consultation fee on the web (both on private websites and the websites of the hospitals at which they have practising privileges); and <p>It would be of greater value if all consultants published on their website (and provided to all patients prior to first appointment) their costs for an initial and follow up consultation, and the total cost (including hospital and anaesthetist fees) for their top ten procedures. Such estimates would provide patients with some basic information on a consultant's charges and help to make a better informed decision when switching costs have not escalated.</p>
<p>"Remedy 7" proposes that all private acute hospitals in the UK collect HES equivalent and PROMs data for private patients, with appropriate arrangements made for publication.</p>	<p>BHF welcomes the proposed requirement for private hospitals to contribute to the HES and PROMs datasets.</p> <p>We note however:</p> <ul style="list-style-type: none"> • Both the HES and PROMs datasets will improve over time (e.g. a wider set of procedures may be covered by PROMs). Therefore the order from the CC must oblige private providers to move ('future proof') with the NHS over time rather than be fixed at today's levels. • To facilitate comparisons between the private sector and the NHS, every private patient should be matched to his or her unique NHS identification number. • Insurers, patients, and GPs must have access rights to these datasets such that they can use these datasets to make better-informed decisions. • The NHS PROMs dataset is currently limited to only four procedures, limiting the coverage across specialisms and the relevance for private treatments. A committed plan of expansion to new procedures in key treatment areas should be included in the remedy for private sector providers. • The CC should ensure that a standardised and comprehensive coding structure exists to complement these datasets. <p>BHF does not believe that PHIN in its current form is the appropriate forum through which to publish data. Currently, only the hospital groups have representation and so conflicts of interest emerge. The PHIN portal itself is difficult to access and validate</p>

⁵² Section 6, http://www.aagbi.org/sites/default/files/code_of_practice_08.pdf (Date accessed: 20th September 2013).

⁵³ <http://www.ombudsman.org.uk/> (Date accessed: 20th September 2013).

	<p>from a commissioner’s perspective (the commissioner requires the raw data). There is no ability to compel providers to contribute to these datasets. Therefore, BHF prefers that the data is collected and held by an independent body like the NHS Information Centre, which is well-established and already builds and maintains similar datasets. If the CC is minded to instruct PHIN or an equivalent to play the information provision role for private healthcare, BHF notes that the governance structure of such an entity must be led by patients/insurers/NHS commissioners. In addition, there must also be committed funding budgets from private hospitals.</p>
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BHF’S ADDITIONAL PROPOSED REMEDIES

6.19 Bupa believes strongly that the CC should take bolder action on information remedies to ensure appropriate information is collected and made available to GPs, patients, and commissioners (insurers). BHF summarises below the key additional measures that, for the reasons explained above, it believes are required in order to ensure that the CC’s remedies are effective in addressing the AECs on information identified in the PFs.

- i. **Standardisation of coding** – a remedy is required to improve industry standardisation of charge codes across treatments currently not covered by CCSD. This is especially critical for the delivery of the following services: therapies, diagnostics, prostheses, drugs, and hospital cost components (accommodation, consumables). This remedy should complement the requirement for the industry to transition across to ICD-10 for impairment coding⁵⁴. Standardisation of coding will help reduce transactional costs in the sector and facilitate benchmarking (e.g. insurers could easily benchmark hospital prices across all services).
- ii. **Mandate minimum dataset requirements for patient safety measures** – this remedy should require all private providers to report the same level of patient safety and clinical quality metrics as in the NHS. This dataset should be agreed by the industry. If the industry cannot come to a consensus, the CQC should hold responsibility in determining what metrics should be collected and reported by providers. Annex B provides a list of the patient safety measures BHF currently seeks to collect from hospitals (although not always successfully given resistance from some hospital groups). From an insurer’s perspective, indicators like unplanned readmission rates and Methicillin-resistant Staphylococcus Aureus (MRSA) rates⁵⁵ are important for guaranteeing patient safety.
- iii. **Match NHS identification numbers with private sector** – this remedy mandates private providers to use a private patient’s unique NHS identification number when collecting and reporting data, not their own identification number⁵⁶. All private patients should be matched to their unique NHS identification numbers (and for international patients without an NHS number, a unique number used across all providers should be assigned). This remedy will facilitate comparisons with the NHS and also enable providers to better understand their patient’s medical history. If a unique NHS identification number is not reported, then more personal data like name, age, and home postcode would be required to match private sector datasets with information in the NHS. Personal data may be legally challenging to collect, publish, and use.

⁵⁴ As of May 2013, Bupa was the only insurer to make impairment coding of invoices a contractual obligation.

⁵⁵ Rate of MRSA bacteraemia per 10,000 bed days as per CQC/HPA definitions.

⁵⁶ NHS identification numbers are not currently collected by private providers.

- iv. **Ban restrictive contractual clauses** – this remedy will ban the use of contractual clauses by hospitals that restrict the use and publication of information by insurers, helping to improve information transparency for the patient.
- v. **Mandatory completion of clinical registries** – clinical registries provide measurement and benchmarking of high-significance clinical procedures. They monitor the safety of new devices, drugs and surgical procedures. Clinical registries are useful in providing information related to specific specialties but currently private consultants have limited incentives to contribute to these datasets on a consistent basis. This remedy mandates the completion of clinical registries⁵⁷. Private patients will be at a disadvantage compared to NHS patients if their data is not entered as activity and performance indicators cannot be benchmarked. Furthermore, commissioners of care should have access to the data on these registries if it is not published in order to be able to manage quality on behalf of patients.
- vi. **Consultant group membership disclosure**. All consultants in groups should disclose this to the GMC and insurers. Monitoring of the size and potential abuse of dominance by groups can only take place if there is transparency on membership.
- vii. **Industry oversight body**. An independent organisation should be established to drive forward and enforce industry reforms, coordination with the NHS, collection of information, and analysis.

⁵⁷ The Healthcare Quality Improvement Partnership (“HQIP”) lists out a set of clinical databases and registers: <http://www.hqip.org.uk/assets/Core-Team/Directory-of-Clinical-Databases-and-Registers-August-2013.pdf> (Date accessed: 26th September 2013)

REMEDY 5 – A RECOMMENDATION TO THE HEALTH DEPARTMENTS

- 6.20 The CC proposes to “*make a recommendation to the health departments or their equivalent bodies in Scotland, Wales and Northern Ireland that they collect and publish on their most appropriate patient-facing website individual consultant performance indicators to include activity and clinical quality measures across the same or an equivalent range of medical specialties to that included in the NHS England scheme*”⁵⁸.
- 6.21 BHF strongly supports the publication of consultant outcome data. There can be clear benefits for patients. However, we have significant concerns that the NHS England initiative is not sufficient and will not be effective in remedying the AEC related to consultant quality identified by the CC.
- 6.22 BHF’s concerns about the NHS England initiative include:
- i. Only 10 of 65 specialisms recognised by the GMC are covered by the initiative. There are plans to extend this, but these are fluid and there no fixed timetable.
 - ii. Table 5 below shows the very limited number of procedures within each specialism for which information is actually published by the NHS England initiative. No more than 20 treatments are covered by the initiative.
 - iii. In terms of consultant coverage, currently the NHS England initiative publishes data on under 4,000 consultants⁵⁹. This is a small minority of consultants in England, where there are well over 30,000 NHS consultants active. The initiative currently misses *at least 70%* of consultants in private practice in England⁶⁰. The initiative also excludes consultants working solely in the private sector with no NHS practice. Any remedy to improve the information collected must include these consultants as well.
 - iv. For the procedures covered, the “outcome” measure typically presented is risk-adjusted mortality rate. However, as many of the procedures have extremely low mortality rates with differences between consultants usually indistinguishable from chance, several of the datasets specifically note that patients should not rank consultants according to these measures⁶¹. Therefore, these mortality measures offer little additional information for patients or commissioners of care on which to differentiate consultants.
 - v. Several of the 10 datasets published under the NHS England initiative already cover consultants from across Great Britain or the UK. So the remedy to recommend Scottish, Welsh and Northern Ireland NHSs to publish consultant data gives limited incremental impact. Furthermore there is no guarantee that the health departments in Scotland, Wales, and Northern Ireland will act on the recommendation in a timely fashion.

⁵⁸ Paragraph 69, CC Remedies Notice, 28 August 2013.

⁵⁹ <http://www.rcseng.ac.uk/patients/surgical-outcomes>.

⁶⁰ A National Audit Office (NAO) report, “Managing NHS hospital consultants”, estimated that 15,754 consultants in England engaged in private practice in 2012.

⁶¹ 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*” (see <http://www.vsqip.org.uk/wp/wp-content/uploads/2013/07/NVR-2013-Report-on-Surgical-Outcomes-Consultant-Level-Statistics.pdf>).

- vi. Even as the coverage of the NHS England initiative grows over time it will only cover a sub-set of procedures that may not be representative of care provided in the private sector.

Table 5: Summary of NHS England initiative coverage⁽¹⁾

Specialism area	Dataset description	Number of procedures covered	Geographic coverage	Number of consultants published
Adult cardiac surgery	<ul style="list-style-type: none"> Number of patients (2011) – 34,760 Coverage across NHS and private hospitals 	4	England and Wales	279 consultants
Vascular surgery	<ul style="list-style-type: none"> Number of patients (2008-12 annual average) – 4,250 Coverage across all NHS hospitals and some private hospitals 	2	England (all) Scotland, Wales, and Northern Ireland (subset who have consented)	Elective repair of an infra-renal abdominal aortic aneurysm – 458 consultants Carotid endarterectomy – 429 consultants
Thyroid and endocrine surgery	<ul style="list-style-type: none"> Number of cases (2009-12 annual average) – 4,400 7 indicators covered including – e.g. in-hospital mortality, length of stay, rate of exploration for bleeding, readmission rate. 	1	UK	125 consultants
Bariatric surgery	<ul style="list-style-type: none"> Number of primary operations recorded (2012/13) – 4,389 Coverage across NHS hospitals only 	3	England	106 consultants
Interventional cardiology	<ul style="list-style-type: none"> Number of Percutaneous Coronary Intervention (PCI) cases (2011) – 88,962 Coverage across NHS hospitals and some private hospitals 	1	UK	Approximately 600 individual PCI operators are listed on website
Orthopaedic surgery	<ul style="list-style-type: none"> Number of cases (2012) – 150,000 Coverage across NHS hospitals 	2	England, Wales, and Northern Ireland	1,594 consultants
Urological surgery	<ul style="list-style-type: none"> 5,449 cases (including 125 private patients from 34 consultants) Coverage across NHS hospitals and some private hospitals 	1	England	283 consultants
Colorectal surgery	<ul style="list-style-type: none"> 27,751 cases (2010-2012) Coverage across NHS hospitals 	1	England	667 consultants
Upper gastrointestinal surgery	<ul style="list-style-type: none"> Number of patients (2011/12) – 2,381 	2	England and Wales	163 consultants
Head and neck cancer surgery	<ul style="list-style-type: none"> Number of cases (2010/11) – 6,879 Coverage across NHS hospitals only 	n/a	England and Wales	c.300 consultants
Total		<20		<4,000

Source: NHS Choices⁶²

(1) Based on information on each datasets website and in some cases telephone interviews with the professional bodies collecting the data.

⁶² <http://www.nhs.uk/choiceintheNHS/Yourchoices/consultant-choice/Pages/consultant-data.aspx> (Date accessed: 20th September 2013).

- 6.23 As discussed in paragraphs 6.19 above and 6.31 below, we recommend that all consultants complete clinical registries that are relevant to their specialisms and that insurers (in addition to GPs and patients) should be able to extract this data easily (to make better informed decisions).

CONSULTATION QUESTIONS

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

- 6.24 Yes – this remedy would, in principle, be practicable in all nations. However, as noted above, BHF does not believe the remedy is sufficient to solve the AEC (even currently in England).
- 6.25 In practice, the practicability of the remedy may be compromised by the fact that all the NHSs are under significant funding strain. Many of the datasets require additional resource at the individual NHS Trust level and from the individual consultant. This places further pressure on already strained resources at a time when the NHSs already have significant change programmes in progress. Therefore, BHF sees a significant risk that this remedy recommendation by the CC may be deprioritised or under resourced (both during set up and going forward). BHF believes that a recommendation to the NHSs (and ultimately taxpayers) risks relying on their limited resources to drive behavioural change that is fundamental to the private sector.
- 6.26 The consultants' whole practice should be covered – both NHS and private across all nations in which they undertook practice. This would maximise sample sizes and so statistical robustness. As noted, many of the ten datasets already span England, Wales and Scotland.

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

- 6.27 No - the ten specialties covered by the NHS England initiative omits a significant number of other specialties and covers only a small minority of consultants and treatments in the NHS (and private practice).

(c) Are the indicators that are currently published for consultants in each of the ten specialties, the way they are presented and the manner of their distribution appropriate?

- 6.28 No – as currently published there is an extremely small set of procedures and metrics covered. Further, the key 'outcome' metric tends to be risk-adjusted mortality rate which does not offer significant insight for the patient (or for the commissioner) when ranking possible consultants. The mortality rates are, for many of the procedures, so low that there is no statistically distinguishable difference between consultants.
- 6.29 The datasets also do not offer easy accessibility for patients or insurers which restricts their use in decision-making or commissioning:
- i. The datasets appear to be published online only through webpages where a single consultant/hospital can be searched at a time (so no batch searching) which makes comparison difficult even if it was appropriate.
 - ii. The data is presented in PDFs or pictures and in aggregated metrics, which prevents the insurer from seeing or capturing the underlying data. This will prevent insurers from using

the data in commissioning. To make better informed decisions, GPs, patients, and insurers should be provided with access to the raw disaggregated data.

- iii. The data tends to be only for one year at a time, limiting the possibility to analyse trends or to monitor the progress of a consultant addressing an identified weakness in their practice outcomes.

Are they (or some combination thereof) appropriate for other areas of specialty? If not, which indicators would it be appropriate to adopt for each specialty and how should they be presented and distributed?

6.30 No – the indicators are not appropriate for other areas of specialty. For example, publishing mortality rates for cataract surgeries is of extremely limited value for commissioners (see paragraph 6.28). In such cases, the number of treatments conducted and effectiveness of a procedure are of more significant value than mortality rates.

6.31 BHF envisions several mechanisms in which significant steps can be taken to improve the quality of information available under each specialism.

- i. For example, BHF would welcome consultants being required to contribute to existing clinical registries that are relevant to their specialism. Clinical registries provide measurement and benchmarking of high-significance clinical procedures. They monitor the safety of new devices, drugs and surgical procedures. Moreover, they are useful in providing activity and quality information related to specific specialties but currently consultants have limited incentives to contribute to these datasets on a consistent basis.
- ii. Typically what happens is an organisation publishes a registry, attempts to get critical mass, and once the registry gains traction, it begins to become a requirement for best practice and professional standards / patient safety / specialty learning. Moreover, clinical registry datasets should be published and easily extractable for commissioners and GPs to analyse. BHF has found it difficult to access and collect clinical registry data easily, even where it does exist today.

6.32 BHF strongly believes that private consultants across all specialisms should publish, at the procedure level, the total number of treatments they have delivered (across both NHS and private practice). Safety can be positively correlated with volume. There should be no reason why this volume data could not be published for patients. In relation to what other indicators would be appropriate for adoption, the existing literature may address this question. For example, Michael Porter's *Redefining Healthcare* discusses the usefulness of some indicators⁶³. In addition, the NHS Outcomes framework details some of the indicators measured in the publicly-funded health sector⁶⁴.

6.33 With respect to how indicators should be presented and distributed, indicators for all private consultants should be published online on a single 'go to' platform to enable easy comparison. The raw disaggregated data should also be easily available for commissioners to extract.

⁶³ Michael E Porter, *Redefining Health Care: Creating Value-based Competition on Results*, 2006.

⁶⁴ <http://www.hscic.gov.uk/iqi> (Date accessed: 20th September 2013).

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

6.34 In theory the remedy may give rise to the unintended consequence of consultants exhibiting risk aversion and not treating high risk cases. However, we note that the NHS England initiative already publishes mortality rates and so this risk exists already in the specialisms covered by this initiative. The NHS England initiative safeguards against the risk by at various points explaining that it is not appropriate for patients to rank consultants only on mortality rates (due to case-mix and chance) but rather to use this as a point of information to discuss with their GP or consultant.

e) With what frequency should performance indicators be updated?

6.35 BHF believes that performance indicators and activity data should be updated at least annually, but ideally quarterly to allow monitoring of performance in near 'real time'.

6.36 BHF notes that currently the NHS England initiative does not appear to have a fixed update cycle across the underlying 10 datasets.

REMEDY 6 – AN INFORMATION REMEDY (CONSULTANT FEES)

6.37 The CC has proposed a remedy with two elements:

- i. Element 1 - “*would require consultants to provide a list of proposed charges to patients in writing, in advance of any treatment*”;
- ii. Element 2 - “*would require all consultants practicing in the private healthcare sector to publish their initial consultation fees on their websites*” and “*would require each private hospital where they have practising rights to publish these fees on their websites.*”

6.38 **BHF welcomes element 1 of this remedy.** The GMC has long required transparency of fees from consultants but this recommendation has been widely ignored.

6.39 In addition, outcome three of the CQC essential standards⁶⁵ (which provides that “*people who pay for a service should know how much they have to pay, when and how to pay it, and what they will get for the amount paid*”) needs to be enforced – the requirement is poorly adhered to and the CQC has never investigated a private provider on outcome three to BHF’s knowledge. Hence, an obligation on consultants to gain full financial consent in advance of treatment will significantly reduce the number of unwelcome surprises for patients and will also increase competition between consultants by increasing the focus of patients/GPs/consultants on the value for money of the care.

6.40 In order to be effective, element 1 of this remedy should include:

- i. **Price information in the fee quotation document:**
 - a. The fee quotation should be presented as early as reasonably possible in the course of the patient’s pathway.
 - b. Fees for each part of the consultant’s proposed course of treatment should be included, with the CCSD charge code and a clear description for each part.
 - c. Where a procedure is likely to require anaesthesia and the appointment of an anaesthetist the fee quote should provide the patient with the name of the anaesthetist and an indicative cost (or at a minimum contact details so the patient can contact the anaesthetist themselves in advance).
 - d. Advice to the patient to check with his or her insurer in advance of proceeding with treatment. BHF does not believe that it would be practical to include details of insurer benefit maxima because different customers have different limits on, for example, annual outpatient benefit limits.

⁶⁵ Outcome 3: Fees – People who pay for a service should know how much they have to pay, when and how to pay it, and what they will get for the amount paid (<http://www.cqc.org.uk/organisations-we-regulate/registering-first-time/essential-standards>).

- ii. **Change control mechanism.** Any change in scope of treatment should be agreed under a separate fee quote document; again, this should be given to the patient in advance of treatment.
- iii. **Standardised fee quotation document:** On presenting a quotation, consultants should provide the patient with a document that includes standard wording that:
 - a. explains the patient's rights and the complaints process available to the patient should there be a dispute with the consultant;
 - b. explains how the patient can compare prices if he or she wishes (this is to give choice to self-pay patients) and how the patient can select an alternative consultant;
 - c. explains where the patient can check consultant quality data; and
 - d. discloses in writing any relevant conflicts of interest the consultant may have.
- iv. **Guidelines and enforcement by established authorities:** the GMC should issue clear guidelines to all consultants outlining the gravity of this requirement and explain that non-compliance may lead to serious consequences.
- v. **Independent scrutiny:** Patients who wish to challenge fee quotes should be informed about and directed to an appropriate independent adjudicator (e.g. Parliamentary and Health Service Ombudsman or Trading Standards). This will allow patients to take complaints against consultants who have failed to explain charges in advance. Patients need a quick, low cost complaints process to ensure that this remedy can be enforced and is effective. Similarly, consultants should have the option of explaining to the independent authority why additional fees were incurred (e.g. due to unexpected complications) and so why any uplift was justified.

6.41 **BHF considers there to be greater implementation challenges and risks of unintended consequences in respect of element 2 of this remedy.** Clearly there are benefits from more transparent and accessible information on consultation fees in allowing patients/insurers to compare fees at a low search cost. But complexities include:

- i. Consultants may not charge the same fee for all patients; for example, he or she may have different outpatient consultation fees agreed with different insurers. This complicates the publication of simple consultation fees that apply across all patients. BHF, therefore, believes the consultant should publish their self-pay outpatient consultation rate and also a list of insurers with whom they have agreed outpatient consultation fees (with the insured patient encouraged to check the fee with the insurer).
- ii. In the absence of consultant quality data the publication of outpatient consultation fees could lead to a 'race-to-the top' with a higher priced consultant incorrectly being perceived as higher quality. BHF has not seen any evidence that higher consultant fees are correlated with higher quality of care.
- iii. The proposal to publish the first outpatient consultation fee could be open to 'gaming' by the consultants. The first consultation fee may be quoted low, with the consultant knowing that he or she will charge higher prices when the patient faces switching costs later in the journey.

6.42 To strengthen element 2 of this remedy we would recommend:

- i. **Communication with insurers:** Consultants should be obliged to notify consultation fees to insurers such that insurers are able to relay this information to customers.
- ii. **Publication of self-pay fees:** Consultants should publish their self-pay outpatient consultation fee on the web (both on private websites and the websites of the hospitals at which they have practising privileges); and
- iii. **Publication of total fees for top ten procedures:** This remedy could be strengthened further if all consultants published on their website (and provided to all patients prior to first appointment) their costs for an initial and follow up consultation, and an indication of average total costs (including hospital and anaesthetist fees) for their top ten procedures.

CONSULTATION QUESTIONS

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

6.43 Element 1 of this remedy requiring consultants to provide a list of proposed charges to patients in writing, in advance of any treatment, is practicable.

6.44 Element 2 of this remedy requiring consultants to publish on a website their fee for an initial consultation would be practicable, but it is subject to a number of complexities and unintended consequences noted above. BHF suggests that this element should require consultants to publish initial self-pay consultation fees and oblige consultants to notify insurers of their fees. Patients should consult with insurers about a consultant's consultation fees and the impact these fees will have on their outpatient benefit limit.

(b) Is it possible for consultants to estimate fees before undertaking a procedure since unforeseen complications may arise? Would there need to be a means of adjusting fees in response to complications?

6.45 Yes – it is possible for consultants to give an indicative estimate of fees before undertaking a procedure e.g. the prices of different diagnostics that will be required.

6.46 Clearly there may be unexpected events that change the fee quoted. However, the patient may agree to the uplift if the consultant can explain to him/her (or to their insurer) the reason for the uplift. Or alternatively the consultant could explain the reasons to an independent authority (e.g. Parliamentary and Health Service Ombudsman or Trading Standards) if the consultant and patient were in dispute.

6.47 Patients should retain the right at all times to challenge an uplift that was not agreed in advance.

Are there particular medical specialties where consultants would face particular problems in providing such an estimate in advance?

6.48 Oncology and other specialties where patients undergo treatment over long periods of time are specialties where consultants may face some problems in providing a 'total' fee estimate in advance. In such cases, consultants should provide estimates of fee on a monthly/quarterly basis.

How else might patients be informed of the likely costs of their treatment?

6.49 No further comments.

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

6.50 Yes it is reasonable to require all consultants practicing in the private sector to disclose their self-pay outpatient consultation fees.

6.51 We do not believe it is practical to ask only those consultants above a certain level of private earnings to disclose their fees. It will be extremely difficult to monitor compliance with the remedy on an on-going basis because consultants' private incomes are confidential.

(d) How should the remedy be specified? How far in advance of treatment should a consultant be required to provide a patient with an estimate of the proposed fees for treatment?

6.52 Paragraph 6.40 outlines details of how element 1 of the remedy should be specified.

6.53 BHF stresses that consultants should be obliged to agree in writing with the patient, at the earliest reasonable time, the fee estimate for the treatment. If the patient feels that he or she was not informed with sufficient notice (in advance of treatment), the patient can register a complaint with an independent ombudsman or adjudicator. Switching costs increase as the patient moves through the treatment journey (even after the first consultation). For there to be any realistic prospect of exercising choice the patient must be provided with the fee estimate at the earliest reasonable opportunity.

Is it practical, in all cases, to inform patients of costs in advance of treatment?

6.54 See paragraphs 6.56 and 6.57.

Should any other information or advice be included with the estimate? For example, should the consultant notify the patient of his or her PMI fee maximum for the procedure concerned, or advise the patient to check this him or herself?

6.55 Please see paragraph 6.41 above. We believe the consultant should encourage the patient to check whether the procedure is covered given that individual policyholders will have different eligibility criteria and policy limits.

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

6.56 An independent adjudicator (e.g. Parliamentary and Health Service Ombudsman or Trading Standards) would assist in making sure this remedy was effective. Where a fee dispute cannot be resolved the case should be reported to the GMC.

6.57 Clearly, the financial consent process should not get in the way of urgent care for the patient. However, given that the significant majority of private activity is elective in nature (rather than emergency) we believe that in the vast majority of cases it is practical to inform patients about costs in advance. In the emergency cases, an appropriately skilled ombudsman (e.g. Parliamentary and Health Service Ombudsman) should be able to determine whether the fees were justified or not.

REMEDY 7 – AN INFORMATION REMEDY (HOSPITAL PERFORMANCE)

- 6.58 The CC has proposed a remedy that “*all private acute hospitals in the UK collect HES equivalent and PROMs data for private patients and that appropriate arrangements are made for its publication to consumers*”.
- 6.59 **BHF welcomes this remedy.** Hospitals do not routinely collect and share consistent activity and quality data for private patients. This remedy would be a significant step forward. However, BHF strongly believes that the CC should strengthen the package further if it is to effectively address the lack of quality information on private hospitals:
- i. The PROMs database for the NHS is currently limited in its scope. It covers only four clinical procedures and hence offers no quality data for treatments in other key specialisms like oncology and cardiology. The remedy should expand PROMs across a wider list of specialisms and establish a committed timetable for implementation.
 - ii. NHS PROMs will be an evolving dataset as the data collected is adapted and the number of procedures covered changes. The remedy must be dynamic and flexible to grow with changes to the dataset. The private sector must at least maintain (‘future proof’) parity with the NHS in the information collected and made available (currently and in the future).
 - iii. PROMs datasets may not be useful on their own. Standardisation and alignment in clinical coding (e.g. CCSD and ICD-10) is critical for the datasets to be helpful in benchmarking performance. The remedy needs to ensure that PROMs outputs are supported by appropriate inputs like impairment coding.
 - iv. Private providers currently do not report basic patient safety measures that are consistently collected in the NHS. The remedy should enforce all private providers to collect and publish consistent patient safety metrics.
 - v. Current hospital-insurer contracts contain contractual clauses that prevent insurers from **sharing** hospital performance/quality data with customers. These clauses prevent insurers from using the data effectively. The CC should establish an outright ban on such contractual terms.
 - vi. Each private patient should have their unique NHS identification number linked to every dataset collected in the private sector. Only then will datasets like HES be useful for making comparisons between the private sector and the NHS. Moreover, the NHS identification number will also enable providers to better understand a patient’s medical history and deliver appropriate care.
- 6.60 BHF also notes that PHIN in its current form is not appropriate to publish this information for private hospitals:
- i. PHIN lacks any oversight of what data is presented or how this data is used by external parties. Currently, only the hospital groups have representation and so conflicts of interest emerge. PHIN lacks committed funding budgets from private hospitals. Moreover, contribution to this dataset is not mandatory and there is no ability to compel providers to do so.

- ii. From a commissioner of care's perspective, the PHIN portal itself is difficult to access and validate. Commissioners need the raw data to make better informed decisions for their patients and customers.
- 6.61 Therefore, BHF would propose that PHIN's data is collected and held by an independent body like the NHS Information Centre (NHSIC). This body should have a clear charter and powers of compulsion. It should also have sufficient representation from different stakeholders in its governance structure to mitigate any conflicts of interest. The NHSIC is well-established and handles large datasets for the NHS and could be an appropriate choice for the private sector.
- 6.62 Alternatively, an independent body focussed solely on the entire private sector could be established to replace a body such as PHIN. BHF notes that patients, insurers, and NHS commissioners must have leadership on the board to ensure that there are no conflicts of interest and that hospitals and doctors are held to account on the provision of data and funding. It should commit to an agreed plan and a set of milestones. Mechanisms must exist such that providers agree to the timetable and devote sufficient resources to the initiative.

CONSULTATION QUESTIONS

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

- 6.63 Yes – it should be possible for all private acute hospitals in the UK to collect HES equivalent data. We expect this is achievable within one year.

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

- 6.64 BHF sees no reason why all private providers should be not be able to collect PROMs data. We believe this collection process should be rolled out within one year.

(c) Besides HES and PROMs equivalent data, what other data should be collected by private hospitals and to whom should it be made available?

- 6.65 BHF would like the CC to develop and mandate 'minimum dataset' requirements for patient safety metrics. At minimum, private providers should be reporting the same level of patient safety and clinical quality metrics as in the NHS. This data should be published such that GPs, patients, and insurers can make better informed decisions along a patient's pathway (see paragraph 6.19).

Would it be appropriate for the CC to specify the coding, for example ICD10, to be used in data collection and classification?

- 6.66 Yes – the CC should mandate reporting of ICD-10 impairment coding for all private providers. This will improve standardisation and will also improve comparability with the NHS.
- 6.67 The CC should also require the industry to standardise charge coding outside of the surgical procedures and therapies currently covered by CCSD. Currently, the a lack of industry standardisation in coding outside of procedures and therapies means that benchmarking and competition is weakened, and different parties each have to incur significant additional

resources in an attempt to process a plethora of different coding from different providers. The CCSD group should be given powers to sanction providers that do not adhere to data coding requirements. The group should have a committed timetable and set of milestones. Mechanisms must exist such that providers agree to the timetable and devote sufficient resources to the initiative.

- 6.68 As shown in Table 6 only around [redacted] of BHF's total claim expenditure is on procedure codes that are standardised across providers. This must be expanded, starting with the recently published CCSD diagnostic test codes. Adoption of further CCSD's standard code sets should be mandated in the industry, and CCSD should be encouraged to proceed with standardisation. Furthermore, all providers must be required to use these codes where they exist.
- 6.69 BHF does not consider it beneficial to replace CCSD with the OPCS-4.6 coding system used in the NHS. Unlike CCSD, which is specifically designed for PMI use as a charge/reimbursement code mechanism, OPCS is not designed to be used for payments. Therefore, OPCS codes are not sufficiently precisely described and many overlap or are ambiguous, so would increase problems of miscoding in the private sector. There would also be a more significant cost to the private sector from restructuring all contracts and systems to accommodate a new coding structure.

Table 6: [redacted]

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

- 6.70 If the CC is minded to use a dedicated body focussed on the private sector, we believe a new body should take on an expanded role to cover both doctors and hospitals. The Board should include representatives from insurers, NHS commissioners, and the public. This will be required to deliver the standards and governance necessary to continue to carry out its activities to a high standard and in the interests of the industry as a whole. Private hospitals and insurers should be obliged to contribute on a pro-rata basis to funding. There must be a clearly agreed programme of work, committed timetable/milestones and end deliverables to deliver the information, with sanctions for non-compliance. This will ensure that any slippage or under-resourcing is detected early.

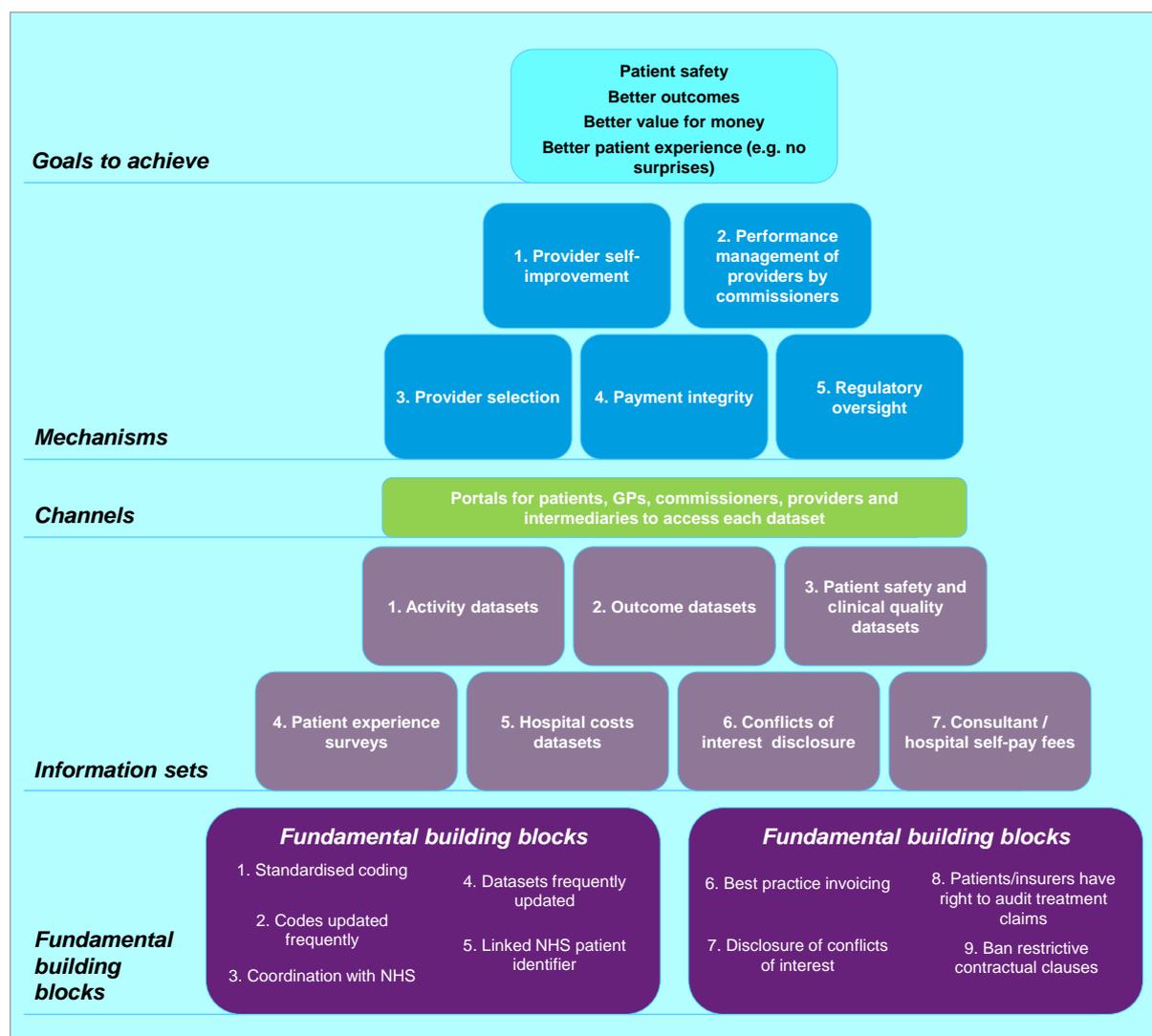
(e) What cost and other factors should the CC take into account in considering the reasonableness and proportionality of this remedy or the timing of its implementation?

- 6.71 BHF believes the following benefits can be realised from the implementation of such a remedy: (i) improved patient safety as better information is available on clinical quality across all providers; (ii) reduced medical indemnity payments as patient safety improves; (iii) reduced transaction costs, and (iv) reduced treatment costs as a result of higher standards of care.
- 6.72 From a commissioner's perspective, an independent body with a charter should be established to enforce this remedy. This organisation should be supported by a third party (e.g. Dr Foster, Picker Institute Europe). Hospitals and doctors should be represented but should not have leadership positions in this body to mitigate conflicts of interest. The body should be funded by insurers and hospitals. The authority should also have powers of compulsion and sanction to ensure providers contribute appropriately to information datasets.

ANNEX A: Well-functioning information system

A.1 BHF’s view of a well-functioning information system is set out in Figure 10 with supporting explanation in the table.

Figure 10: Detailed framework for a well-functioning information system



Source: BHF

Table 7: Building blocks of a well-functioning PH information system

Level	Block	Description
Mechanisms	1. Provider self-improvement	<ul style="list-style-type: none"> Hospitals and consultants can use the data available to benchmark performance so as to improve efficiency. The metrics providers can use to benchmark performance include but are not limited to: outcomes data including clinical, regulatory data and PROMs; complication rates; "Never events"; operational success rates; length of stay; place of treatment; cost of treatment; adherence to best practice; correct diagnosis success rate; utilisation rates; other patient safety metrics.
	2. Performance management of providers by commissioners	<ul style="list-style-type: none"> Commissioners of care must be able to benchmark data on mass so that unwarranted treatment patterns can be assessed and addressed. This comparative information will also be critical to negotiations between insurers and hospital groups.
	3. Provider selection	<ul style="list-style-type: none"> GPs, patients, and commissioners of care can access information to assess provider performance and value for money to make informed decisions. Patients, GPs, and commissioners should also be made aware of any incentive arrangements between consultants and hospitals.
	4. Payment integrity	<ul style="list-style-type: none"> Data available to commissioners of care to ensure treatment costs are appropriately and efficiently reimbursed.
	5. Regulatory oversight	<ul style="list-style-type: none"> A regulatory authority able to monitor and act upon poor provider conduct
Information sets	General	<ul style="list-style-type: none"> Information sets need to be bridged such that they can be used side-by-side. For example, activity datasets should be analysed in conjunction with outcome datasets. Information datasets should be collected and presented in a standardised format to enable benchmarking
	1. Activity datasets	<ul style="list-style-type: none"> These datasets should include detailed entries that record every activity (e.g. procedure, diagnostic tests) conducted by each provider. They should be as disaggregated as possible. Examples of such datasets include but are not limited to: Hospital Episode Statistics (HES), Secondary Uses Service (SUS).
	2. Outcome datasets	<ul style="list-style-type: none"> These datasets should include detailed entries that record the quality of care delivered to patients by each provider. Reliable data, linked to individuals and provider organisations, should be collected to enable the comparison of treatment outcomes. One example is Patient Reported Outcome Measures (PROMs). Clinical registries provide measurement and benchmarking of high significance clinical procedures. They also may be established to monitor the safety of new devices, drugs and surgical procedures. Examples of clinical registries include but are not limited to: Association of Upper Gastrointestinal Surgeons - National Oesophago-Gastric Cancer Surgery Registry; Biliary Drainage and Stent Registry; British Society of Blood and Marrow Transplantation Registry; Thoracic Stent Graft Registry; UK Renal Registry
	3. Patient safety and clinical quality datasets	<ul style="list-style-type: none"> These datasets should include detailed entries that record patient safety and clinical quality metrics such as infection rates, re-operation rates, return to theatre rates.
	4. Patient experience surveys	<ul style="list-style-type: none"> These datasets should gather the views of patients about the care they recently received; including complaints data. For example, the Picker Institute Europe is an approved survey provider for the NHS. These datasets should measure in a consistent and standardised manner how a patient viewed his or her experience with a consultant and/or hospital.
	5. Hospital costs datasets	<ul style="list-style-type: none"> These datasets should collect and report costs of a treatment, procedure, and pathway by each provider. Cost datasets are necessary to enable efficiency benchmarking of hospitals. The costs collected should be itemised (e.g. core surgical costs, hospital room costs, anaesthetist costs) 'Must have' hospitals should report financial accounts (profits/costs) separately such that commissioners can assess whether prices are abnormally high.
	6. Conflicts of interest disclosure	<ul style="list-style-type: none"> These datasets should report every financial and non-financial disclosure of interest held by a GP, consultant, and hospital. BHF believes that consultant incentive schemes should be banned (see Section 5)
	7. Consultant / hospital self-pay fees	<ul style="list-style-type: none"> These datasets should report all self-pay prices by each provider (consultant and hospital).

ANNEX B: Sample of minimum safety metrics

B.1 BHF seeks to collect safety metrics from hospitals, although the completion rates by many hospitals are patchy and inconsistent. Figure 11 below lists a sample of safety metrics BHF seeks to collect from hospital operators. This could form a foundation of a minimum safety dataset for the industry which was mandatory for all hospital operators to complete and regularly update.

Figure 11: [✂]