PRIVATE HEALTHCARE MARKET INVESTIGATION

CIRCLE HEALTH LIMITED

Further Response from Circle to Provisional Findings and Remedies Notice

December 2013

Following submissions from other providers, PMIs and other interested parties in relation to the CC's proposed remedies, Circle wishes to make a further submission in relation to Proposed Remedy No.4 (Consultant Incentives).

The CC recognized correctly that enabling consultants to own the facilities in which they provide clinical services may actually lower barriers to entry and therefore encourage competition. It explains why Circle (Bath and Reading) and KIMs (Maidstone), each co-owned by consultants, are the only recent new market entrants to offer full-service secondary care to privately insured and self-pay patients. Despite this fact, many of the incumbent providers and PMIs have cynically argued that equity ownership by consultants should be banned, invoking an array of specious arguments. It's ironic and transparent that those arguing most vociferously against consultant ownership are the very same operators (BMI and Ramsay) who previously operated the discredited "cash-for-patients" schemes. Their sudden hostility to all forms of consultant incentives, including the equity ownership model that has enabled Circle and KIMS to build new state-of-the-art hospitals in the same markets where they operate, should be seen for exactly what it is: naked self-interest.

Circle responds to each of these arguments below.

1. ***Equity ownership distorts clinical decision-making and undermines patient care***.

   This argument rests on the misconceived notion that consultants will treat their patients in facilities in which they have an ownership stake, even when it is not clinically appropriate, because they will benefit financially from doing so. There is a misapprehension that equity ownership is designed to reward consultants for making referrals to the facility in which they have an interest, whereas in reality the aim is to incentivize them to provide their patients with the best possible care. There are a number of reasons why this incentivisation does not undermine their independence in decision-making.

   First, under GMC rules, a consultant is obligated to disclose his/her ownership stake before the patient makes the decision about where he/she will be treated. Any potentially distortive effects are eliminated through this act of disclosure. If the patient does not want to be treated at that facility or believes that the consultant's ownership stake in that facility poses an unacceptable conflict of interest, then the patient can elect not to be treated there. In effect, the patient has the power to over-ride any potential for distortion. In practice, the consultant will likely hold practising privileges at another facility (in which the consultant does not have an ownership stake), as many of our consultant partners in fact do. As a result, the patient is free

to seek treatment at the other facility.

Second, many other professional services are beset with the same kinds of inherent conflicts facing consultants and have adopted means of managing them. For instance, most law and accounting firms charge their clients on an hourly basis. Much of their work, like the work of doctors, is of a technical nature that is inscrutable to their clients. As a result, there is an opportunity for lawyers and accountants to charge their clients for unnecessary research or work. Despite these inherent conflicts, lawyers and accountants are duty-bound to act in their clients' best interests and are expected to adhere to the highest standards of ethical conduct. In other words, they are expected to self-regulate their conduct. And, where such conduct falls short of the ethical standards of their profession, the relevant professional bodies have the power to impose sanctions, including the withdrawal of their right to practice their profession. Similarly, the GMC requires its members to "act with integrity" and make the care of their patients their first concern. These are important mechanisms for ensuring that consultants place the interests of their patients before anything else, as the vast majority of them do even without the threat of professional sanction. Indeed, to suggest otherwise is to imply that consultants are somehow less able to adhere to their ethical obligations than lawyers and accountants. Furthermore, the argument that equity ownership somehow blinds consultants to their obligation to their patient's well-being is both offensive and completely unsupported by any empirical evidence. It should go without saying, yet given the feverish reaction of our competitors on this point it is worth noting, that there is absolutely no evidence to suggest that any of our consultant-owners has ever referred a patient to one of our facilities for a reason that was not clinically appropriate or justified. Accordingly, to propose a remedy so drastic as the outright prohibition on consultants owning their own practices or holding an equity interest in the facility in which they practice requires significantly more than the mere potential for a consultant to violate his/her professional ethics.

Fourth, equity ownership is already widespread in the UK medical profession. Many smaller specialty practices (e.g., ophthalmology, dermatology, cardiology, MSK, mental health) are clinician-owned and a significant majority of all primary care practices are GP-owned. Despite this, it has never been seriously suggested that these arrangements somehow create an insurmountable conflict or undermine the quality of patient care, despite the fact that some GP practices effectively self-refer their patients for a range of clinical treatments for gastro/intestinal conditions, pulmonary conditions, diabetes, rheumatism, pain management, etc. Why then does the extension of the ownership model to larger, full-service providers somehow create unique conflicts or competition concerns, as some competitors and PMIs suggest, the solution for which is to restrict or ban the model altogether? If an ophthalmologist can own his own clinical practice (and, of course, he should if he wishes), why can't he also own an interest in a hospital in which he provides the same clinical services?

Fifth, Circle's senior managers have received training regarding the scope of the Bribery Act and have taken measures to embed an anti-bribery culture throughout the Circle group. The Bribery Act would only be relevant to consultant incentive arrangements in the extreme circumstance where the grantor intends to use the incentive for an improper purpose, e.g., to induce the consultant to treat a patient at the grantor's facility when it is not clinically appropriate. This has never been the case at Circle and, again, no party participating in the CC's market investigation has offered any evidence demonstrating that equity arrangements are designed for an improper purpose. The suggestion that an improper purpose exists simply because it theoretically could is spurious and intellectually flawed. Circle's equity ownership model plainly does not fall within the purview of the Bribery Act.

Finally, Circle believes that far from undermining patient care consultant ownership actually improves it. The problems associated with under-performing hospitals, in both the private and public sectors, to a significant degree stem from a lack of ownership and sense of responsibility among front-line staff. Co-owning their facility encourages consultants to take more responsibility for the overall care provided there (and not simply the treatment they provide to their patients). Many of our consultants are actively involved in designing more effective clinical pathways, identifying waste and poor practice, participating in the clinical and operational governance of their facility, and enhancing the overall patient experience. They do this because they are motivated by professional and financial self-interest to protect the reputation and ensure the best possible clinical outcomes of their facility. But to be clear: the long-term and diffused nature of equity ownership means that the financial reward can only ever be a consequence of the quality of care provided (in contrast with the various "cash-for-patients" schemes the incumbent providers have deployed). A facility with poor outcomes and patient satisfaction will not attract patients over time and will not be financially viable and therefore the equity held by consultants will be meaningless. Conversely, when a facility is able to attract more patients by virtue of the high quality of care provided and the collective involvement of consultants who work there, then we think it is entirely appropriate that consultants be able to share in the financial success of that facility. Employee and clinician ownership is the cornerstone of the Circle model and is the principal reason why we are able to achieve consistently outstanding patient satisfaction levels at our hospitals.

2. *Consultants should not be "locked in" to a certain hospital*

This argument is misconceived, as it rests on the assumption that a clinician with an equity stake in a hospital is contractually bound to treat all of her patients at that hospital. This is not the case with the Circle model: Circle does not require its consultant-owners to commit to treating 100% of their private patients at a Circle facility. Some may do out of choice but virtually all our consultant-owners maintain practicing privileges at other facilities. Consequently, patients wishing to be treated at another facility by a particular consultant can do so and, likewise, a consultant wishing to see

patients at a non-Circle facility can do so. There is therefore no "locking in", either in theory or in reality.

Even where a consultant elected to treat all of his/her patients at a facility in which he/she held an equity interest, we submit that it is entirely permissible to do so provided such treatment is clinically appropriate. In the event that a patient does not wish to be treated at the facility (either because the patient does not like the hospital or believes the consultant's ownership interest poses an insurmountable conflict), then the patient is free to seek treatment somewhere else. It is completely unjustified to dictate to consultants how they should organize themselves or structure their practices when patients have the right to be treated wherever they choose.

3. ***Other jurisdictions (e.g., US) have banned or proscribed certain clinician ownership arrangements***

This argument focuses on the so-called "Stark Law" in the US. To the best of our knowledge, no other jurisdiction operates anything close to an outright ban on clinician ownership arrangements, nor has any respondent to the Remedies Notice drawn attention to any other such jurisdiction.

The Competition Commission will be familiar with the Stark Law, as it is referred to in the Remedies Notice. There are a large number of reasons why the Stark Law is not a useful model for a remedy here in the UK, among them:

- The Stark Law covers Medicare and Medicaid patients only. Its clear aim is to regulate the use of public funding of US healthcare, which is beset by sky-rocketing costs and widespread fraud.

- The Stark Law is a very blunt instrument, originally designed to tackle fraud and runaway healthcare costs rather than to deal with competition issues. Its origins in the anti-fraud context mean that it is not a suitable precedent for addressing the complexities of local and national market conditions that any competition law remedy must consider.

- The Stark Law only covers particular designated medical services, mainly diagnostic testing, and not all services that doctors may offer.

- The guidelines, notices and other literature which help to explain and interpret the Stark Law are lengthy and complicated, and in many cases ambiguous. Introducing a similar law in the UK would create great confusion rather than clarifying the current position.

- The costs of monitoring compliance with a regime such as the Stark Law would be considerable, given this complexity and ambiguity.

4. Operators should compete on price and quality only

Circle agrees that quality should be the greatest factor on which operators should compete, and understands that price is also very significant. There are, however, two key points in relation to this.

First, operators can compete on price and quality only where there is a level competitive playing field – in other words, low or no barriers to entry, no structural issues making competition difficult and no anti-competitive or other unfair practices which affect the market. This is not the case currently in the UK. In situations where incumbents have an unassailable position and can use that position to block new entrants, potential new entrants in particular must be able to find ways around that block, in order to increase choice for patients.

Second, the Circle model of equity ownership of facilities by all employees of that facility is one facet of competition on quality, insofar that it encourages Circle employees to work hard and perform well, thereby increasing quality for patients. It is therefore not possible to separate the concept of competing on quality from the Circle model. Circle appreciates that not all consultant incentives are designed to promote quality of service to patients, and that many are a means for operators to compete to attract the best consultants – however, where the incentive is offered to all employees and clinicians delivering care, as in the Circle model, it becomes clear that the focus is very different than other forms of incentives used by incumbents.

5. Current ownership arrangements should be unwound

Circle disagrees strongly with this argument. As stated above, equity ownership of private healthcare facilities has enabled the only two recent new market entrants (Circle in 2010 and KIMS in 2014) to enter and compete head-to-head with the incumbents. Any proposal to unwind current arrangements or prohibit new arrangement gives rise to many different uncertainties, including:

- How would equity be divested? To whom? How much? When? At what value?
- What kind of existing ownership arrangements would be unwound and which would be prohibited from forming? Full-service acute care groups? Specialist practices? Diagnostic services? Equipment manufacturers? Joint ventures? Solo practitioners? Private GP practices? What criteria would be applied? By whom?
- What would be the impact of equity divestment on competition in the Reading, Bath, and Maidstone markets?
- Would divestment encourage providers to acquire or partner with consultant practices or hiring consultants as employees (thereby ensuring they are "locked in" and exacerbating the very problem the remedy was intended to resolve)?

As the foregoing suggests, none of the arguments offered by the incumbents to justify banning or proscribing consultant ownership is persuasive.

Finally, there is a fundamental point to be made about the rights of the consultants to organize themselves as they desire. There is something inherently unfair and discriminatory about preventing consultants from owning their own businesses and dealing with their patients/customers through those businesses, when other professionals and tradesmen are perfectly entitled to do just that. Provided that there is adequate disclosure to patients, sufficient safeguards against fraud and exploitation, and the ability for patients to go elsewhere, fairness dictates that consultants should be entitled to provide their services in the same way as any other service provider.