

Nuffield Health's provisional response to the Competition Commission's notice of possible remedies report on 28th August 2013

Introduction

- 0.1 Nuffield Health recognises the progress made by the CC in its provisional findings document, and welcomes the opportunity to help the CC assess the potential ramifications of remedies being explored.
- 0.2 At this stage we are still discussing and evaluating the remedies proposed by the CC, and as such would like to make clear that this document contains our provisional response to the CC's notice of possible remedies
- 0.3 Overall Nuffield is encouraged by the CC's progress to date on developing possible remedies to address AECs in the market and believes the types of intervention being considered have the potential to benefit the consumer
- 0.4 The key points which we make through the course of this document include:
 - Divestiture is a crucial remedy to rebalance the market power that currently resides [Redacted], and is the only practicable structural remedy which addresses these concerns
 - Divestments should be taken as far as is practically possible to address the AECs caused by the market power [Redacted]. Outside of central London, divestiture needs to rebalance the portfolios of hospital operators such that no single player controls a critical mass of 'must-have' hospitals. Divestiture should therefore also be considered in strategic insurer markets that the CC has classified as 'single' or 'duopoly'
 - Divestiture is not comprehensive [Redacted]. As such, we believe additional remedies are required to support divestiture and prevent the 'bundling and tying' of hospitals in national insurer negotiations
 - The remedies proposed by the CC to address the 'bundling and tying' of facilities each have issues such that, in Nuffield Health's opinion, they will not fully prevent the AEC caused by the market power [Redacted]
 - Nuffield Health is currently considering alternative remedies, which it will aim to share with the CC as soon as possible
 - Restrictions on expansion need to be reconsidered by the CC. In its current form, such an intervention would likely generate an unlevel playing field between incumbents and new entrants

- Consultant incentives, as the CC has recognised, distort the referral pathway to the detriment of the consumer. As such, Nuffield supports a complete ban

- And finally, Nuffield is aligned with the CC around the need for better fee and performance data to inform patients, GPs, and PMIs. While most of the CC’s suggestions are sensible, the collection and dissemination of HES data will not prove helpful.

0.5 In line with the structure of the possible remedies report, Nuffield has divided its response into the following sections:

- Competitive distortions in the market
These are the market characteristics which give rise to AECs. If a remedy does not address at least one of these distortions, we will argue it is ineffective

- Nuffield’s views on remedial action
This section reviews the 7 suggested remedies outlined in the report. For each remedy, Nuffield will highlight any key areas of weakness, answer any direct questions from the CC, and establish any co-dependence between different remedies.

0.6 As with previous submissions, if any remedy proposed by the CC is not addressed directly by this response, please do not infer tacit agreement. We reserve the right to comment on any unaddressed remedies at a later time

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1. Competitive distortions in the market

1.1 In line with our response to the CC's provisional findings, Nuffield believes there are 4 key market characteristics giving rise to AECs that should be addressed by the CC's remedies. It is the ability of any remedy to alter or mitigate these market dynamics that will determine whether or not Nuffield views these remedies as effective:

1. The **current levels of market power** [Redacted]
2. **Weak competitive constraints** across many local markets. A situation which is sustained by high structural and non-structural barriers to entry.
3. **Bargaining dynamics** enabling hospital operators of scale to circumvent local competition through national arrangements with PMIs
4. Distortions affecting the **referral pathway**, such as information asymmetries and consultant incentives

1.2 We consider these characteristics when evaluating whether a proposed remedy is effective (i.e. constitutes an improvement to the status quo) and comprehensive (i.e. fully addresses the above characteristics without the need for further remedial action).

2. Possible remedy assessment: divestiture

Overall position

2.2 Nuffield views divestment as an essential structural remedy for addressing:

- Current levels of market power [Redacted]
- The weak competitive constraints that exist in markets where an operator owns multiple hospitals

2.3 However, [Redacted] the divestiture remedy should be extended to include the right proportion of 'must have' facilities owned [Redacted], such that it reduces the market power of [Redacted] operators as far as is reasonably necessary.

2.4 Furthermore, divestiture is not comprehensive [Redacted], and as such we believe additional remedies are required to support divestiture and prevent 'bundling and tying' of hospitals in national insurer negotiations

2.5 [Redacted]

Detailed assessment – Central London

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?

- 2.6 Nuffield Health believes that a divestiture programme is an appropriate remedy for central London. For a more detailed exploration of the specific hospitals chosen for divestment, please see our pending submission addressing the CCs proposed divestiture packages.
- 2.7 Given that concerns in London relate to the limited outside options for PMIs during negotiations with HCA, Nuffield Health thinks it sensible to provide those PMIs with more outside options through forced divestment.
- 2.8 However, divestiture alone will not prove comprehensive in addressing competitive distortions in central London. An appropriate divestiture package would need to be accompanied by some measure aimed at reducing HCA's capacity to incentivise consultants to move between its divested and retained facilities.
- 2.9 If consultant drag cannot be overcome, then an acquirer might reasonably expect the attractiveness of any divested facility to decline materially post-acquisition as patients treated by top-performing consultants are distributed among other HCA facilities.
- 2.10 In terms of criteria for specifying a divestiture package, it is unclear to Nuffield what precisely was being referenced. If the CC is referring to the list covered in point 21 (appropriate package, suitable purchasers, and effective process), then at a high level these considerations appear sensible.
- 2.11 Nuffield would like to make explicit the requirement for any divestiture to be made fairly available on the open market to all suitable and interested parties if it is to effectively address AECs. Were implicated parties able to swap assets, then new entrants would be precluded from acquiring, which defeats (at least in part) the rationale for any forced divestment.

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?

- 2.12 Nuffield is confident that appropriate purchasers are available which fulfil its 3 stated criteria (expertise, commitment, and financial resources).

2.13 The CC should exercise caution in determining which bidders are deemed appropriate purchasers in order to avoid further AECs. No doubt any prospective acquirer would help alleviate CC's concerns somewhat regarding the weak competitive constraints facing HCA at a local level. Nuffield's concern however, is whether such acquisitions would confer additional leverage during national insurer negotiations.

– [Redacted].

– [Redacted]

2.14 Regarding the bundling of assets at sale, Nuffield believes there are 2 factors that require the CC's consideration:

1. *Appropriate package*

Nuffield believes the hospital(s) in question are sufficiently large to be able to compete effectively on a stand-alone basis, as is evidenced by the London Clinic.

2. *Suitable purchasers*

While there are a number of appropriate acquirers with the required expertise and commitment, the availability of financial resources is likely to be a constraint if the assets in question are bundled. Selling assets individually would also offer more choice to the consumer and consultants. Similarly, separate purchasers provide PMIs with a greater range of providers to negotiate with when seeking network coverage in central London.

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?

2.15 Nuffield does not view divestiture on its own as sufficient in addressing the limited competitive constraints facing HCA. This is primarily due to circumvention risks pertaining to consultant drag.

▪ [Redacted]

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 PPUs. Would divestiture of any such assets or businesses present particular problems?

2.16 Nuffield understands the CC to have carried out analysis in this area, particularly regarding vertical integration. Given that no AEC has been found in relation to HCA's ownership of

GP practices, we see no reason why these assets should be included within a divestiture package. In terms of PPU contracts, Nuffield notes that these are not the primary assets contributing to HCA's market power in London, and therefore do not appear to contribute materially to consumer detriment.

– [Redacted]

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?

2.17 Nuffield believes HCA will still remain the strongest operator in the London market, despite the proposed divestiture package. This places constraints on any acquirer at the local level. That said, the risk of an acquisition conferring market power locally increases if divested facilities are bundled together.

2.18 However, there is a material risk that the acquisition of an HCA hospital will confer additional leverage to the operator during national insurer negotiations if they also have a number of 'must have' hospitals outside of London. Therefore remedies to prevent the tying and bundling of hospitals in insurer negotiations would need to be enforced in order to minimise such a risk.

How long should HCA be given to effect the sale of the divestiture package?

2.19 Nuffield is aligned with the CC in thinking that 6 months should be the maximum period granted to sell the proposed assets. Indeed, that was the rough timeframe taken during Nuffield's disposal of the portfolio of 9 hospitals to BMI.

2.20 Given that the proposed divestiture packages specified are materially simpler than the bundling of Nuffield's nine facilities, we see no grounds on which the CC should consider extending its usual window, and it might be able to specify a shorter window accordingly.

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

2.21 Nuffield Health feels unable to comment on the specifics of a central London divestment, but presume the framework to balance costs to the operator with benefits to the consumer. Benefits to the consumer presumably include greater choice, increasing levels of hospital innovation and investment, and lower prices in both the self-pay and insured markets. In terms of cost, we presume that the only areas for consideration are the operational outlay from the hospital group to effect such a change, and a minor loss of any scale benefits.

2.22 We do not believe there to be other less costly or intrusive remedies that would similarly stimulate competition in central London.

Detailed assessment – outside central London

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?

- 2.23 Again, Nuffield Health believes the proposed divestments are essential and effective but not comprehensive. This is acknowledged by the CC when discussing options for ‘single’ or ‘duopoly’ markets. We will discuss in turn the potential limitations of divestiture in addressing current levels of market power nationally afforded to BMI and Spire, and weak competitive constraints locally, which harms self-pay patients.
- 2.24 This remedy is an effective way of resolving common ownership concerns that arise from clusters of hospitals across a given region. Importantly, the relative size of each hospital in the cluster must be considered:
- In a market like Manchester, a forced divestment of several satellite facilities may resolve competitive concerns for the self-pay market (presuming consultants are willing to operate in these hospitals after divestment).
 - [Redacted]
- 2.25 This leads us to the second limitation of divestiture, which concerns single or duopoly markets. For divestiture to be considered comprehensive, the leverage conferred by ownership of ‘must-have’ facilities (hospitals with high market share in markets with a high concentration of corporates) would have to be mitigated.
- At present, the number of ‘must-haves’ in the portfolios of dominant hospital operators is far higher than those of other market participants. In order to mitigate the leverage conferred by these facilities and drive greater competition nationally, this disparity would have to be narrowed. The CC would be unable to do this unless it considered addressing the must-haves of dominant hospital operators in single or duopoly areas [Redacted]
- 2.26 Nuffield appreciates that such a remedy would require very careful consideration to avoid transferring too much market power to a prospective acquirer. We therefore propose that divestiture is taken further than is presently being considered, but also complimented with remedial action addressing the tying and bundling of an operator’s hospitals.

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?

2.27 As before, Nuffield believes there are appropriate purchasers available for these divestments, but the CC should ensure the hospitals are made fairly available on the open market to all suitable and interested parties, rather than simply swapped between implicated operators.

2.28 Similarly, as with London, there should be limits placed on any acquisition by existing operators of scale.

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?

2.29 Given the proposed scale of divestiture outside London, Nuffield does not consider the remedy comprehensive. This remedy needs to be considered in conjunction with a ban on consultant incentives and the aforementioned addressing of tying and bundling.

2.30 As with London, the divesting hospital operator can offer certain incentives to consultants if they transfer their practice to a retained regional facility. This includes the leveraging of unnamed referrals (see point 2.16). Furthermore, where the divesting party retains a regional 'must-have', entrenched unnamed referrals from GPs are likely to remain with the wider group rather than transfer to the acquirer. This provides the divesting party with a material advantage over any prospective new entrant.

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?

2.31 Nuffield Health believes PPUs should be considered for divestment in the same way as other types of hospital. However, we note that many of these facilities are not the primary drivers of market power across local markets.

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?

2.32 This question cannot be addressed at such a general level. Given the prevailing dynamics of insurer/hospital operator bargaining, market power is conferred through the concentration of 'must-have' facilities across the entirety of a hospital operator's portfolio. The CC therefore needs to consider the benefits and potential risks of permitting hospital operators with market power nationally to acquire assets identified for divestment.

How long should BMI and Spire be given to effect the sale of the divestiture package?

- 2.33 As with London, Nuffield Health believes a maximum window of 6 months should be granted (see 2.21 - 2.22).

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

- 2.34 As with London, at a general level the framework should balance costs to the operator with benefits to the consumer. Benefits to the consumer include greater choice, increasing levels of hospital innovation and investment, and lower prices in both the self-pay and insured markets. In terms of cost, the CC's analysis should consider the operational outlay from the hospital group to effect such a change, and the loss of any scale benefits.
- 2.35 We do not believe there to be other less costly or intrusive remedies that would similarly stimulate competition across the rest of the UK, but reiterate the need for divestiture to be implemented alongside a solution to bundling and consultant incentives.

3. Possible remedy assessment: preventing tying or bundling

- 3.1 Ahead of clarifying our position around those remedies addressing bundling and tying, we set out which behaviours interventions should preclude.
- Conceptually, the CC should address the circumvention of local competition through national bargaining strategies. This is achieved through tying the network status and pricing of an operator's hospitals in relatively competitive markets to its other hospitals in less competitive strategic markets (what Nuffield and some insurers have termed 'must-haves').
- 3.2 Practically, this tends to be achieved indirectly through one of two bargaining tactics:

1. National price tiering

As Nuffield explained in its response to the CC's provisional findings, certain price tiering configurations constitute de-facto tying. In these configurations PMIs are penalised if they wish to contract with a subset of a hospital operator's portfolio. This is achieved through:

- a. Offering PMIs highly inflated prices for low network volumes
- b. Supposedly 'discounting' these inflated prices beyond what economies of scale could reasonably justify
- c. Negotiating thresholds for these 'discounts' at volumes that guarantee universal network approval, and [Redacted], form barriers to entry by

securing network exclusions for competitors and new entrants in locally contested markets

2. The threat of revised contractual terms

Certain nationally agreed PMI contracts may contain clauses which enable the hospital operator to renegotiate prices if the insurer changes its network of approved hospitals. These clauses may take the following form:

- Should revenues from the PMI fall in a particular hospital by more than a specified percentage per annum then the entire national pricing agreement can be renegotiated.
 - This clause can be triggered if such a fall can be linked back to a change in the PMI's hospital network (i.e. through the recent recognition of a local rival)

In this way, dominant hospital groups are able to use price threats to deter the recognition of excluded rival facilities across a PMI's network.

- 3.3 Having laid out the mechanisms by which operators bundle and tie hospitals in national insurer negotiations, Nuffield now considers each of the possible remedies outlined by the CC.

Overall position

- 3.4 In summary, Nuffield believes that **none of the proposals outlined** will prevent hospital operators from tying group hospitals together during negotiations without leaving insurers exposed to the leveraging of must-haves:
- (2a) addresses the threat of revised contractual terms, but does not preclude a hospital operator from engaging in national price tiering
 - Conversely, (2b) addresses the issue of national price tiering, but still leaves PMIs exposed the leveraging of 'must –haves' locally

- 3.5 We therefore believe the CC needs to consider or refine these suggested remedies to more fully address competitive distortions.

Detailed assessment – (2a) banning price rises in response to PMI network changes

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

- 3.6 Nuffield believes this remedy would prove ineffective for 2 reasons: It would not address volume-based price tiering, and would still allow [Redacted] to leverage their 'must have'

hospitals to continue charging inflated prices. Each of these will be addressed in turn below.

- 3.7 As was previously mentioned, existing arrangements between PMIs and dominant hospital operators contain nationally agreed volume-based pricing levels. Such price tiering arrangements do not require contractual revisions to penalise PMIs if they recognise a rival facility or delist an operator's hospital. Unless these contractual arrangements are banned (which seems unreasonable given economies of scale at the individual hospital level), hospital operators could circumvent this remedy.
- 3.8 The second weakness with this remedy concerns its reliance on current contractual terms. [Redacted] Given the status quo, preventing further price rises does not address the fundamental issue with current pricing levels, which should not be taken as a base. Nuffield Health would therefore favour remedial action which tackles the inflated prices currently being secured [Redacted].
- 3.9 Given these two deficiencies, Nuffield will only address further CC questions pertaining to (2a) that impact remedial action more broadly.
- 3.10 *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?*
- 3.11 N/A

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?

- 3.12 Nuffield refers back to its response to the CC's provisional findings, points 3.5 – 3.11 in particular.
- 3.13 In summary, hospital operators can reasonably offer volume discounts at the single hospital level given economies of scale. These economies are driven by declining average fixed cost per procedure as volumes rise.
- 3.14 At the group level however, cross operator volume discounts can only be justified on the basis of falling average group overhead per procedure, which Nuffield contends is a negligibly small proportion of total average cost per procedure.
- 3.15 As has already been outlined, these contractual arrangements constitute the de-facto tying of must-haves to hospitals in more competitive local markets.

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?

3.16 N/A

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

3.17 In its current form, this remedy would require the regulation of national price tiering over and above what economies of scale might suggest is reasonable. Nuffield imagines the complexity of such an exercise would make this variant of the bundling remedy unworkable.

Detailed assessment – (2b) individual hospital pricing to PMIs

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

3.18 As Nuffield has no recent experience of negotiating with PMIs on this basis, the following comments should be taken as informed conjecture.

3.19 Nuffield expects that offering individual hospital pricing would be significantly more complicated and costly than existing national bargaining arrangements. That said, we are open to pursuing the idea if such an arrangement addresses the tying of hospitals.

3.20 Our primary concern is that hospital operators with market power could still continue to leverage their 'must have' facilities to incentivise PMIs to direct volumes to them. Furthermore, with a more costly and complicated series of negotiations, PMIs would be incentivised to tender their network less frequently. Were that the case, non-structural barriers to entry might increase.

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?

3.21 Nuffield sees no reason why such a remedy could not be brought into effect after contracts with PMIs expire. These contracts are typically renegotiated at three-to-five year intervals, which Nuffield Health sees as a material barrier to the speedy implementation of a tying/bundling remedy. We would certainly hope that the CC could find a way to correct the AECs brought about by the aforementioned contractual terms before these contracts expire.

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

- 3.22 As the CC alludes to in its line of questioning, there are issues with this remedy in Single hospital areas, and in regions with 'must-have' hospitals.
- 3.23 If reputational risk could be relied upon to deter anticompetitive behaviour, then we would not have seen 'must-haves' being leveraged during national insurer negotiations to the extent that they are. Given such reputation concerns do not seem to have deterred hospital operators with market power, we think the CC should not rely on operators exercising pricing restraint regarding prices in markets such as Edinburgh.
- 3.24 Furthermore, the sequencing of negotiations might be used to employ game theoretic bargaining strategies by hospital operators. For example, it would be very difficult for the CC to enforce a ban on punitive price offerings in some markets as a form of retaliation for delisting in others (a 'tit for tat' strategy).
- 3.25 Nuffield would also want the CC to clarify that when it references BMI, HCA, and Spire offering and pricing '*their hospitals separately and individually to PMIs*', that no cross network pricing provision could be inserted to circumvent local competition.

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?

- 3.26 As Nuffield Health mentioned in its response to the CC's findings, market entry does not depend entirely on existing prices in a market, but also sustainable anticipated pricing levels after entry (and levels of underlying demand). The CC itself acknowledges that '*in a static market any incumbent could be expected to react very aggressively to entry, and that this expected reaction would deter entry*'.
- 3.27 Assuming entry in markets where prices are inflated is therefore unreasonable, as prospective entrants could reasonably expect the incumbent to lower its pricing in an effort to leverage greater scale (presuming the incumbent is larger). This is especially pertinent in markets with insufficient demand to sustain two competing facilities, where we would anticipate an incumbent's response to be more pronounced.
- 3.28 As a result, the business case for entry would not stack up and the CC cannot expect hospital operators to behave as though the market is 'contestable'.

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?

- 3.29 Such a remedy would place additional bargaining power in the hands of PMIs, and the CC should consider the consequences of increasing buyer power if it were abused.
- 3.30 Nuffield can foresee a scenario where hospital delisting becomes increasingly common. While this might potentially have the short term impact of securing lower prices for PMIs, it would also require consultants to split their practice between multiple facilities. Furthermore, if network exclusions force smaller operators to close and drive up levels of local concentration, PMIs may leave themselves exposed longer term to new 'must-have' hospitals.

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?

- 3.31 The capacity of a PMI to profitably delist a hospital is contingent on their ability to direct volumes away from the facility in question. Otherwise the PMI is faced with high 'out-of-contract' charges if treatment occurs at a non-approved hospital. The ability of a PMI to secure reasonable prices locally therefore is tied into the credibility of its outside options.
- 3.32 These options will be effected by the majority of consultants preferring to base their practice at a specific hospital. As such, individual hospital pricing would need to be introduced in conjunction with a complete ban on consultant incentives.

4. Possible remedy assessment: restrictions on expansion

Overall position

- 4.1 Nuffield Health believes that restrictions on incumbents partnering with NHS Trusts will result in an unlevel playing field between new entrants and incumbents. This is primarily due to the shifting composition of procedures at private hospitals:
- In recent years, Nuffield has seen the prevalence of higher acuity procedures in a private setting increase. In smaller markets in particular, a PPU may offer the only feasible environment in which to deliver these services.
 - Banning a partnership with the local Trust would constrain an incumbent's capacity to respond to market trends, and enabling new entrants to do so results in an unlevel playing field.

Detailed assessment – restrictions on expansion

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

4.2 Such a remedy would restrict an incumbent's capacity to expand, but would not address current levels of market power conferred by hospitals [Redacted].

4.3 It should also be noted that PPUs are only one route to expansion, and acquisition or hospital expansion present other opportunities to expand in single and duopoly markets.

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

4.4 Nuffield believes hospital operators would consider forming PPU partnerships in areas where they do not have an existing presence. Nuffield points to HCA's Christie PPU as a recent example of this type of arrangement.

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?

4.5 Aside from the unintended unlevel playing field already discussed, Nuffield also believes there would be one further unintended consequence worth the CC's consideration.

4.6 In certain markets, Nuffield has considered investing materially in the development of a Trust's PPU, which, once complete, would be partially funded by the sale of its existing hospital in the region.

4.7 If incumbents were precluded from partnering with PPUs, the market may be deprived of investment in local provision even in situations where local concentration would reduce. This reduction in concentration could be expected as the sale of an incumbent's existing hospital would allow a new market participant to enter.

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

4.8 Nuffield fails to see how any such consumer detriment would arise, save for the foregone investment in newer equipment in the region.

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?

4.9 For reasons already divulged, Nuffield believes this remedy should not be implemented in its current form, and has no strong views on who is best place to enforce these regulations.

5. Possible remedy assessment: banning consultant incentives

Overall position

- 5.1 Nuffield is aligned with the CC around the need for a complete ban of consultant incentives in cash or kind. However, the CC will need to be careful in considering the implications of loopholes offered to new entrants that use consultant incentivisation to lower barriers to entry.

Detailed assessment – banning consultant incentives

Is the remedy practicable? What framework of rules could be used to determine reasonably and practically whether the benefits of an incentive scheme in terms of lowering barriers to entry, outweighed the distortions created? What degree of oversight would be required to monitor compliance and who should fund it and exercise monitoring? How could the 'fair market price' test be monitored and enforced and who would be responsible for doing so?

- 5.2 Nuffield believes such a ban is practicable, and would anticipate that any breaches should be reported to the OFT, as with any other illegal anticompetitive behaviour. We encourage the CC to think about the extent to which exceptions to the ban are required for new entrants.

- Given the CC is proposing to ban incumbents from incentivising their consultants, and providing the CC addresses the barriers to entry caused by infrequently tendered exclusive insurer networks, Nuffield Health does not see a need for new entrants to provide their consultants with an incentivisation package (e.g. equity offerings). It is our hope that by lowering barriers to entry through divestment, the prevention of tying, and this remedy, any new entrant will be able to compete for consultants on the basis of the quality of its facility. It is precisely this type of competition that will promote the consumers' interests.

- 5.3 In terms of the cost benefit analysis which determines whether a new entrant is permitted to offer consultant incentive schemes, Nuffield Health thinks the CC should consider:

- What constitutes market entry? Nuffield thinks that such exceptions should only be open to new builds
- Is there a timeframe after which a new entrant is considered an incumbent and incentivisation schemes are therefore repealed? Nuffield thinks this an important consideration to avoid new entrants being treated advantageously longer term. The CC could require, for example, that any incentivisation package be time limited or revoked once the costs of building a new facility have been covered.

- Such a provision would mean that equity could not be issued as an incentive

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

- 5.4 Nuffield believes it sensible that certain provisions hospitals offer consultants be considered 'de minimis'. This would save the requirement to calculate fair market rates for those services that would never be borne in mind when a consultant is choosing which hospital to base their private practice in. To avoid circumvention however, only very low value services should be exempt.

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

- 5.5 Granting hospital operators carte blanche with regards to existing arrangements seems to defeat the purpose of such a ban. Nuffield Health is unaware of the cost of unwinding existing equity sharing arrangements.

Particularly in the context of market entry and expansion, are any relevant customer benefits likely to arise from equity participation by consultants in hospitals that would not otherwise be available?

- 5.6 Nuffield does not believe the consumer benefits from equity participation by consultants. These are exercised strategically to secure consultant buy-in, and are a purely commercial arrangement.

6. Possible remedy assessment: performance information on consultants

Overall position

- 6.1 Nuffield views the need for better consultant performance information as a consensus issue. We believe annually updated information on consultant quality should be made available to patients, GPs, and insurers alike.
- 6.2 We believe the CC's proposals regarding the collection and dissemination of '*performance data for individual consultants in ten medical specialties*' are sensible.

7. Possible remedy assessment: consultant fee information

Overall position

- 7.1 Nuffield Health is aligned with the CC on the need for consultant fee information and believes the dissemination of such information on hospital operators' and consultants' websites is a good idea.
- 7.2 Most of our consultants regularly perform around five core procedures. A consultant's fees for these procedures tend to be relatively standardised, and do not vary a great deal between different patients. As such, we believe the average fee charged for a consultant's five most common procedures to be the most appropriate data to publish.
- 7.3 We believe our consultants should be able to inform patients of anticipated charges in advance of treatment and that professional bodies such as the royal college of surgeons should be responsible for the oversight and enforcement of this remedy.

8. Possible remedy assessment: hospital performance information

Overall position

- 8.1 As we outlined in our response to the CC's provisional findings, we support the drive for the collection and dissemination of better quality information on our hospitals.
- 8.2 However, Nuffield does not believe HES data will properly inform the public about the quality of our hospitals. We point the CC to the 'NHS Hospital Data and Datasets' consultation carried out by the Health and Social Care Information Centre. The report comments that '*HES suffers from a number of shortcomings and it simply does not meet the needs of a modern health service*'.
- 8.3 Furthermore, collecting HES data will be a costly exercise, especially in terms of IT system requirements. Such increases in the cost of treating patients privately will likely be passed on to the consumer.
- 8.4 PROMS, on the other hand, is both easy to collect and a helpful source of information. We appreciate that this data could be complimented by the collection of outcomes based data. To establish what form this might take, Nuffield suggests PHIN takes the lead on consulting patients on what factors are most important to them and how would they like information presented.