

SPIRE HEALTHCARE

**COMPETITION COMMISSION
PRIVATE HEALTHCARE MARKET INVESTIGATION**

REDACTED RESPONSE TO NOTICE OF POSSIBLE REMEDIES

11 NOVEMBER 2013

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1. INTRODUCTION AND EXECUTIVE SUMMARY

1.1 Spire Healthcare Group (*Spire*) submits these representations in response to the Competition Commission (*CC*)’s Notice of Possible Remedies under Rule 11 of the *CC*’s Rules of Procedure (*Notice of Possible Remedies*) in the private healthcare market investigation.¹

1.2 As explained in detail in Spire’s Response to the *CC*’s Provisional Findings Report (*the PFs*), the provisional conclusion that the *CC* has identified a feature (or features) of the market which give rise to an AEC pursuant to section 134 of the *Enterprise Act 2002 (EA02)* is unreasonable and unlawful. The *PFs* disregard actual evidence of competition, including evidence of competition provided by the Private Medical Insurers (*PMIs*). Instead, the *PFs* are based on a mechanistic and formulaic account of the market that is inappropriate and wrong.

1.3 In simple terms, the standard of proof (*i.e.*, establishing an AEC to the balance of probabilities) is not discharged. Indeed the standard of coherence and robustness of evidence and analysis that the *CC* must reach is heightened when it proposes to use its most draconian of remedy powers: the power to compel divestment. As the most interventionist remedy, divestment should only be used where the conclusions are based on the most concrete of evidence and the most robust of analytical steps. Where, as is the case here, the available evidence is mixed, the analytical steps are tenuous, and the conclusions so unreasonable, divestment is not a remedy legitimately open to the *CC*.

1.4 There is therefore no AEC and no need for a remedy. Even if any remedy were justified, the specific remedies proposed by the *CC* are in many cases simply not fit for purpose. As explained in detail in the remainder of this submission, several of the proposed remedies would not be effective to achieve the aim sought (even if that aim were justified). In many cases, the proposed remedies would also be disproportionate, have unintended adverse consequences, and/or be complicated, expensive, and time-consuming to implement.

1.5 Finally, any remedies imposed must be proportionate to the consumer detriment resulting from any AEC. However, the *CC*’s analysis of consumer detriment is not economically sustainable. In particular, the *CC* uses unreasonable and irrational assumptions to estimate a projected “overcharge,” and proceeds to assume that any benefits of lower prices will be passed through to consumers, even though that assumption is not backed up by any evidence or analysis.²

1.6 Spire’s analysis of the seven specific remedies proposed by the *CC* (and the price control remedy considered and rejected by the *CC*) is summarised in the table below. Spire’s views on each of these remedies are also explained in more detail in the remainder of this submission.

¹ The document is also responsive to the *CC*’s request for additional information of 18 October 2013.

² A more extensive description of the flaws in the *CC*’s analysis of consumer detriment is provided in Chapter 8 of Spire’s *PF Response*.

Summary of proposed remedies

Proposed Remedy	Spire's Position
<p>Remedy 1: Divestiture of 3C</p>	<ul style="list-style-type: none"> ▪ <u>No remedy at all is justified</u>: the CC's analysis of an AEC with respect to cluster hospitals 3C is fundamentally flawed. ▪ <u>No evidence that divestiture here would be an effective remedy</u>. The PCA does not support a divestiture 3C and nor does any other evidence. Evidence of actual market practice shows strong and effective competition 3C. ▪ 3C. ▪ The <u>divestiture of 3C would be particularly disproportionate</u>, as it would force Spire to divest assets that play no role whatsoever in the CC's theory of harm.
<p>Remedy 2(a): Prevention of price rises in response to PMI network changes</p>	<ul style="list-style-type: none"> ▪ <u>No remedy at all is justified</u>: the PFs do not identify any AEC resulting from tying, bundling, or national discount schemes. ▪ The <u>application of the remedy remains wholly unclear</u> and therefore it is difficult for Spire to comment meaningfully on it. ▪ The remedy appears to apply to <u>price rises made in the context of already concluded agreements</u>. If this is the case, <u>it has no connection to Spire's business</u>: Spire cannot unilaterally raise prices for any reason under the terms of its existing contracts with PMIs. ▪ Spire is concerned, however, that the remedy could be interpreted more widely. In this case, <u>the remedy would not be reasonable or effective</u>. The remedy would simply introduce "local" pricing, but in a far more cumbersome and complex way than Remedy 2(b). The remedy would create significant market uncertainty, and have several adverse unintended consequences, such as distorting competition between hospitals and between PMIs and ending pro-competitive network and volume-based discount policies.
<p>Remedy 2(b): Requiring hospitals to be offered and priced separately and individually</p>	<ul style="list-style-type: none"> ▪ <u>No remedy at all is justified</u>: the PFs do not identify any AEC resulting from tying, bundling, or national discount schemes. ▪ Despite this, the <u>remedy could be implemented without material practical difficulty</u> given sufficient time 3C
<p>Remedy 3: Prevention of owner of Single or Duopoly hospital from partnering with NHS Trust to operate PPU in same area</p>	<ul style="list-style-type: none"> ▪ <u>No remedy at all is justified</u>: the PFs do not identify any AEC to the requisite legal standard. ▪ Notwithstanding the requirement for any remedy at all, this would be likely to create additional opportunities for entry by new providers to a given geographic area. ▪ The remedy would, however, only operate effectively if a <u>clear and effective set of rules and enforcement mechanism</u> could be established (which remains unclear at present).
<p>Remedy 4: Prevention of consultant incentives</p>	<ul style="list-style-type: none"> ▪ Spire agrees with the CC that <u>direct incentives in the form of payments for referral should not be permitted</u>. ▪ However, the CC appears to <u>overstate the scope and potential impact of incentive arrangements</u>. The <u>proposed remedy risks preventing certain arrangements that benefit patients</u> by bringing new facilities, services, and consultants to the market. ▪ Any remedy must be <u>proportionate</u>. A Stark Law-type remedy would be wholly disproportionate. A disclosure-based monitoring scheme overseen by Monitor would be a more effective and proportionate way of achieving the CC's aims.
<p>Remedy 5: Publication of individual consultant performance</p>	<ul style="list-style-type: none"> ▪ No additional comment, as Spire supports the submissions of PHIN.
<p>Remedy 6: Publication of consultant pricing</p>	<ul style="list-style-type: none"> ▪ No additional comment, as Spire supports the submissions of PHIN.
<p>Remedy 7: Publication of information on private hospital performance</p>	<ul style="list-style-type: none"> ▪ No additional comment, as Spire supports the submissions of PHIN.
<p>Remedy 8: Price control</p>	<ul style="list-style-type: none"> ▪ <u>This is not an appropriate remedy</u>. A price control remedy would be impossible to design, specify, implement, and monitor within the context of the private healthcare market. It would have the unintended consequence of harming investment in better quality services and introducing new procedures.

2. REMEDY 1: DIVESTITURE OF X

Overview

- **No remedy at all is justified: the CC’s analysis of an AEC with respect to cluster hospitals X is fundamentally flawed.**
- **There is no evidence that divestiture would be an effective remedy X. The Price-Concentration Analysis does not support a divestiture X and nor does any other evidence.**
- **In fact, evidence of actual market practice shows that there is already effective competition X.**
- X.
- X.

2.1 The proposed divestiture appears to be targeted at “*weak competitive constraints*” X, alleged to arise as the result of a “*cluster*” of hospitals owned and operated by Spire. The CC apparently considers this likely to give rise to an Adverse Effect of Competition (AEC) by virtue of “*higher prices for self-pay patients*” 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.*”³

2.2 For the reasons explained more fully in Spire’s Response to the Provisional Findings (*PF Response*), the CC has not met the requisite standard of proof to show an AEC such that the CC’s power to seek a remedy is engaged. As Spire has explained in some detail in its PF Response, there is no such AEC X.

2.3 There is no evidence whatsoever – including from the CC’s Price-Concentration Analysis (*PCA*) – that the divestiture of a Spire hospital X would have the effect of increasing price competition in X. By contrast, the available evidence relating to how the market actually works in practice (which the CC once again appears to ignore) shows that there is already sufficient competition X.⁴ Accordingly, Spire considers that no remedy at all is justified. Indeed, it is particularly difficult for Spire to comment on the reasonableness and effectiveness of a specific remedy where it cannot see that any remedy at all is justified.

2.4 Nonetheless, for the purpose of the hypothetical analysis of possible remedies, Spire responds to the CC’s questions below. These observations are, of course, entirely without prejudice to Spire’s substantive challenge to the CC’s Provisional Findings.

³ Provisional Findings, para. 10.3

⁴ See Confidential Annex 1.

(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?

Divestiture would not be an effective remedy

2.5 Even if the AEC identified by the CC had been established to the required standard, and any remedy at all were justified, the proposed remedy would still not be effective, and is therefore unlawful.

2.6 In deciding whether to impose any remedy, the CC must show that the specific remedy proposed would have the effect of remedying the precise AEC identified.⁵ Without this, the CC cannot lawfully conclude that the remedy is required. The CC must therefore be able to show that the proposed remedy – *i.e.*, the divestiture of \mathcal{X} – would have the effect of leading to increased price competition in that area, in turn leading to a reduction in price for self-pay and insured patients.

2.7 However, there is no reliable evidence that the divestiture of \mathcal{X} – would have that effect:

- (a) **The PCA does not support a divestiture \mathcal{X} .** The PCA does not show any effect of concentration on self-pay prices for Spire:
- (i) In assessing a remedy \mathcal{X} , the only relevant consideration is what Spire would do in that area. Market-wide averages do not predict the likely impact of the remedy at any individual Spire facility. To take these broader market-wide averages into account would be inappropriate and wrong and, in the context of framing a specific remedy, amount to taking into account an irrelevant consideration. Put simply, the only relevant evidence that the CC can take into account is specific evidence relevant to Spire \mathcal{X} .
 - (ii) Even if the CC could draw a broad market-wide AEC conclusion from its PCA results (which it cannot), the results do not hold for Spire. The PCA carried out with respect to Spire does not show any effect of concentration on self-pay prices.
 - (iii) Moreover, even if the PCA analysis did show any effect of local concentration on self-pay prices \mathcal{X} (which it does not), this conclusion cannot be automatically extended to insured prices. Insured prices are determined in a materially different way to self-pay prices. Any assessment of the effect of local concentration on insured prices has to be based on the analysis of insured data only. The CC's analysis of insured prices showed that Spire does not consistently or significantly price above operators without market power. The CC has failed to

⁵ *Enterprise Act 2002*, section 138.

present evidence that lower concentration will result in reduced insured prices.

- (b) **The evidence available to the CC shows that there is already sufficient competition ✗.** The CC claims it has not used the LOCI for a mechanistic assessment of competition in local areas. However, the CC’s approach to formulating the proposed divestment is almost exclusively based on changes in this LOCI parameter. This is clearly not a proper basis to frame any potential divestment package because it cannot account for any qualitative assessment of competition in the relevant local area. The confidential qualitative evidence available to the CC (which is set out in Confidential Annex 1) clearly shows that there is already sufficient competition ✗ and therefore that any divestiture in this area would not be effective.
- (c) **PCA/LOCI analysis shows that divestiture would not have any effect.** The PCA is not an “across the board” result that applies equally to all market participants and does not suggest that higher concentration leads to higher self-pay prices in the case of Spire. The CC therefore has no basis to presume that a divestment that decreases Spire’s local concentration ✗ would be beneficial. On the contrary, the evidence indicates this would make no difference to competition.

The CC has identified candidates for divestment based on how that impacts on the “network effect.” However, because the LOCI screen is misconceived, hospitals may become candidates for divestment (*i.e.*, the network effect may increase) as a result of facing greater competition.⁶ There is therefore no basis (even in theory) to presume that the divestment of ✗ would be required, and hence no basis to presume it would increase local competition.

- (d) **The market conduct of key insurers demonstrates that there is already sufficient competition ✗.** The actual market conduct of key insurers indicates that the divestiture of ✗ would have no effect on competition ✗ because local competition is already sufficient. ✗.

2.8 In sum, there is no evidence that requiring Spire to divest ✗ would be an effective means of achieving the CC’s stated aim of increasing price ✗. The remedy proposed would not be effective and is therefore unlawful.

2.9 Even if the CC’s LOCI-based test for divestment is applied, ✗.

- (a) Using the CC’s test, candidates for divestment are those for which the “network effect” – *i.e.*, difference between the “individual LOCI” and the “network LOCI” – exceeds 0.2.
- (b) ✗.
- (c) ✗.

⁶ See Spire’s Response to the PFs.

(d) ✗.

2.10 ✗.⁷ ✗.⁸

(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?

There are a significant number of potential purchasers

2.11 In the event that the CC (wrongly and unlawfully) concludes that a divestiture would be an effective remedy ✗, there would likely be a significant number of entities with the appropriate expertise, commitment, and financial resources to run the divested facility as an effective competitor.

(a) **Larger UK-based hospital operators.** Other larger UK-based operators would likely have an interest in acquiring the divested assets (as Spire itself might potentially be interested in purchasing hospitals divested by other PHPs). National operators have considerable expertise and experience in operating hospital facilities and would clearly be able to run any divested facility as an effective competitor.

Bupa has suggested that it would have “*significant concerns*” if any divested assets were to be purchased by a hospital group such as BMI, HCA, Nuffield, Ramsay or Spire, arguing that this would “*expand that group’s scale and could increase the proportion of the group’s portfolio that comprises ‘must have’ facilities.*”⁹ Bupa indicates that it is concerned that the acquiring group would be able to “*leverage the [acquired facilities] to increase national prices through tying or bundling practices.*”¹⁰

However, there is no reason that additional constraints should be placed on such operators acquiring divested facilities. As a matter of law, any restrictions of this nature would be inconsistent with the CC’s theory of harm (which is premised on the ownership of a “cluster” of hospitals in a given local area). In any case, it is not clear who would in practice be able to purchase the (significant body of) divested assets if a blanket ban was placed on their acquisition by larger current hospital operators. The acquisition of any divested assets by larger current hospital operators should therefore simply be subject to the same competition analysis (*i.e.*, merger control review) as any other acquirer or acquisition.

(b) **Smaller UK-based operators.** Existing smaller UK-based hospital operators would be well placed to operate and develop the divested facility as an effective competitor. Hospitals owned by several smaller operators (such as

⁷ ✗.

⁸ ✗.

⁹ Bupa Health Funding, *Response to Remedies Notice*, para. 4.58.

¹⁰ Bupa Health Funding, *Response to Remedies Notice*, para. 4.118.

Aspen) already operate as effective competitors in various locations across the UK.

- (c) **International operators.** Several international operators could take this opportunity to enter the UK market. For example, Nueterra Healthcare International, the US-based healthcare group, has indicated to the CC that it has been developing its potential entry into the UK private healthcare market for the last two years.¹¹ The Al Noor Hospitals Group, a private hospital provider based in the United Arab Emirates (which recently listed on the London Stock Exchange), is also understood to be considering potential entry into the UK.
- (d) **PMIs.** PMIs have previously purchased hospitals (*e.g.*, Bupa acquired the Cromwell Hospital in London in 2008) and may also be interested in purchasing any divested assets.¹²
- (e) **Private Equity Firms.** Private equity firms may also be interested in purchasing any divested assets. Several private equity firms have purchased and successfully operate (or have operated) private healthcare businesses in the UK, including Cinven's current ownership of Spire Healthcare Group, Apax's part-ownership of GHG/BMI, Legal & General Ventures' acquisition of a group of private hospitals from BUPA Hospitals in 2005 to form the Classic Hospitals group (subsequently acquired by Spire in 2008), and Welsh Carson Anderson and Stowe's ownership of Aspen Healthcare. A financial purchaser could easily acquire any sector-specific expertise necessary to run the business (*e.g.*, by hiring staff from outside the UK or from existing UK competitors).
- (f) **NHS.** Depending on location and proximity to other NHS facilities, the NHS might also have an interest in purchasing any divested assets.

The MIR process may impact the availability of suitable purchasers

2.12 In assessing the availability of suitable purchasers (and therefore the effectiveness of the remedy), the CC should consider the impact that the MIR process is likely to have on potential purchasers. The CC's extraordinary approach to profitability and the risk-return available to investors raises serious questions about whether firms would be prepared to continue to invest in the UK private healthcare sector. Moreover, given the number of substantial hospitals that the CC is proposing would come to market at the same time, it is not clear that there would be a sufficient number of purchasers to acquire all of the divestment properties, particularly within the relatively short timeline for divestiture that the CC appears to have in mind.

¹¹ See Nueterra Healthcare UK Limited, Nueterra Submission to Competition Commission, para. 1.2.

¹² Bupa appears to acknowledge, in its response to the proposed remedies, that PMIs could be interested in purchasing divested hospital assets. See Bupa Health Funding, *Response to Remedies Notice*, para. 4.59.

There is no clear framework for competition analysis of potential purchasers

2.13 Spire is unable to consider whether the acquisition of the divested assets by particular purchasers would create further competition concerns, in particular for two reasons:

- (a) First, Spire has no means of replicating the CC's LOCI analysis, which has been central to its assessment of local competition. Absent access to such analysis, Spire (like all other parties active in the marketplace) is not able to determine whether the CC would consider that the acquisition of the divested assets by another operator (particularly a larger UK-based hospital operator) would raise further competition concerns.
- (b) Second, Spire is not able to assess the weight that would be assigned in a local competitive assessment to factors such as inpatient or other admissions, critical care availability, geographic proximity, or specialties offered. The CC has suggested that these real-life competitive parameters have been taken into account in its assessment, but this is not reflected in the CC's conclusions (which are largely based on theoretic assumptions).

2.14 In order for Spire to be in a position to make informed representations on this point, the CC must provide further disclosure and/or explanation of the reasoning that it has adopted. Spire has asked for this information on several occasions, but it has not been forthcoming. For Spire to be able to respond properly to the CC's question and to put its case, it needs access to the detail of the CC's analysis.

(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 divestment measure?

Consultant Availability Arrangements

2.15 In the event that the CC (wrongly and unlawfully) concludes that any divestiture is necessary, the CC will need to consider how arrangements between hospitals in relation to consultant availability will work in practice.

2.16 This is important to understand, because where a divestiture hospital draws its consultants from the same Trust as another hospital being retained by the same operator, it may be necessary to introduce a "no poaching" rule (*i.e.*, an arrangement effectively akin to the sort of "non-solicit" agreement one would commonly expect to find in an M&A agreement).

2.17 An effective non-solicit agreement would need to meet the following criteria:

- (a) It would need to be carefully delineated to ensure that the benefit of acquiring a hospital passed to the new owner, but not to prevent the retained hospital from continuing to compete for both consultants and patients. So, for

example, consultants would need to remain free to choose to base their work in one hospital (if they so choose) or to split their practices between one, two, or more hospitals.

- (b) Any limitations would need to be time-limited and geographically limited in order to avoid the CC introducing market distortion that would undermine future competition.

2.18 ✕.

(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 PPU's. Would divestiture of any such assets or businesses present particular problems?

2.19 ✕.

2.20 ✕:

(a) ✕;

(b) ✕; and

(c) ✕.

2.21 ✕.

2.22 ✕.¹³

2.23 ✕.¹⁴

(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?

2.24 ✕.

(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?

2.25 The CC's guidelines provide that the sale of a divestiture package should "normally" have a maximum duration of six months in "relatively straightforward divestiture cases."¹⁵

¹³ ✕.

¹⁴ ✕.

2.26 The basic process of allowing all possible buyers to look at all possible assets – *i.e.*, for “*canvassing a sufficient selection of potential suitable purchasers to facilitate effective disposal and adequate due diligence*” within the terms of the CC’s Guidelines – will take some time. The CC would also need to review and approve all divestitures. These processes would be complicated by a number of factors arising out of the way in which the CC has formulated its proposed remedy, in particular:

- (a) Spire (and other hospital groups) cannot easily assess the universe of possible buyers for any facility. The CC’s local competition analysis is based on a flawed LOCI, which cannot be replicated. Where other quantitative or qualitative features of competition have been cited by the CC, it is not possible to understand how these have been applied in practice.
- (b) Only a buyer without any existing hospital facilities in the same geographic area as a divestiture hospital could be sure of passing the CC’s competition test. However, there is not likely to be a sufficient number of such potential purchasers to acquire all divestiture assets.
- (c) Spire has limited internal resources to manage the process of selling hospital assets at the same time as assessing the potential purchase of assets divested by other parties (and the same would likely be true for other purchasers).
- (d) In some cases, landlord or lender approval may be required for the disposal of a hospital site.¹⁶ Some time may therefore be required for the landlord and/or lender to carry out their own due diligence into the proposed new tenant. There can be no guarantee that a purchaser acceptable to the CC would also be acceptable to a landlord or lender. At the very least, the CC cannot assume that any consents required would be forthcoming or that the process would be swift.
- (e) The disposal of hospitals will also be complicated by the fact that no purchaser of a divestiture facility is likely to proceed without confirmation from the relevant PMIs that they will recognise (or continue to recognise) the hospital as part of their network. This is an important feature of the disposal process that has been exacerbated by the current inquiry. The CC has acknowledged that PMIs routinely use instances of new openings, service expansions, and hospital transfers as a material part of their bargaining strategies.¹⁷ Indeed, this was Spire’s experience with respect to the recognition of its Montefiore facility.¹⁸ Spire would expect PMIs to use the opportunity of the CC’s

¹⁵ Competition Commission, *Guidelines for market investigations: Their role, procedures, assessment and remedies*, Annex B, para. 27.

¹⁶ Similarly, material contracts with third parties that support the operation of a divested facility would require to be novated (requiring the consent of contractual counterparties).

¹⁷ See, *e.g.*, Provisional Findings Report, Appendix 6.11, para. 164 *et seq.* The CC notes that a PMI “*may seek to withhold recognition if it perceives that by doing so it can secure improved terms in return for recognition*” (at para. 164), and cites several examples in which the recognition of a new facility was “*part of a negotiation*” of where a PMI was able to “*secure a discount in return for recognizing a new facility*” (at para. 169).

¹⁸ ✂.

proposed re-shuffling of the competition landscape to delay and/or deny recognition, and/or renegotiate existing agreements as a condition for continuing recognition. (The CC's failure to engage with this systemic problem in the private healthcare marketplace is discussed more fully in Spire's PF Response.)

- (f) Purchasers would be required to obtain additional regulatory approvals, such as CQC registration. Obtaining these approvals can take some time (*e.g.*, CQC registration can take up to eight weeks).

2.27 Notwithstanding these difficulties, the standard six-month period set in the CC's Guidelines should be sufficient to ensure an effective disposal of the divestiture assets. However, in light of the potential for delays to arise (*e.g.*, in securing the required consents from landlords/lenders or where purchasers are unwilling to complete transactions because of uncertainty injected by PMIs) a flexible timeline and process may be needed. The CC would have to keep the progress of the divestiture process under close review with a view to extending the time period required.

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

2.28 Spire cannot identify any benefits that would arise from the proposed divestiture. The CC has not adduced any evidence showing that Spire hospitals price higher to self-pay patients in areas where concentration is higher or that Spire's insured prices are consistently or significantly above those of operators without market power. The CC therefore cannot lawfully conclude that there would be any price benefit from a divestiture ✕.

2.29 By contrast, any divestiture could have significant "costs" for the divested asset. These costs could damage the operational effectiveness of the divested asset, potentially increasing the cost of healthcare to end-users and/or decreasing the quality of services provided. When the CC is considering whether any remedy is justified, it should give particular weight to these costs (given the absence of any benefit whatsoever):

- (a) **Loss of efficiency.** Spire is an extremely efficient operator of hospitals, including ✕ (as the CC is aware from the extensive evidence provided). In the course of the present inquiry, Spire has commissioned LEK Consulting to prepare detailed assessments of its profitability.¹⁹ These assessments have provided extensive evidence of Spire's efficiency of operation (*e.g.*, ✕ of the improvement in Spire's EBITDA between 2007 and 2011 has been generated by the realisation of operating efficiencies).²⁰ These efficiencies may well be lost in the hands of another operator, ultimately leading to higher costs for consumers.

¹⁹ LEK Consulting's report is attached as [Annex 7](#) to Spire's PF Response.

²⁰ Spire's Response to the Annotated Issues Statement, Appendix A, p. 76.

- (b) **Loss of clinical excellence.** The CC is also aware from the evidence provided that Spire has invested significantly in the underlying clinical processes and treatment pathways that support its clinical excellence. Again, these performance advantages may be lost in the hands of another operator, ultimately resulting in the divested hospital suffering from a loss of competitiveness (including from reduced consultant confidence in the facility).
- (c) **Negative impact on planned investment.** ✗.
- (d) **Negative impact on future investment.** As a general matter, the CC's proposed approach could serve to chill competition by reducing the incentive for local entry or expansion by incumbent providers. For example, Spire would not be able to assess, using the criteria used by the CC, whether the purchase or development of new facilities would lead to a "cluster" in future.

2.30 There are therefore significant cost disadvantages that the CC has not recognised (and that the CC's analytical framework is ill-equipped to consider). These are, however, important issues for the CC to take into account because they are key to how a hospital competes for patients in a local area: on quality and on price.

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

2.31 Spire considers that the remedy proposed by the CC is wholly disproportionate on a number of bases:

- (a) **No remedy is necessary at all.** The CC should consider whether any remedy is necessary at all. There is no substantive basis on which the CC can reach a lawful conclusion that a local remedy is required ✗. Where a decision on remedy is marginal due to the wealth of evidence on the effectiveness of local competition, the CC needs to be more confident that a positive effect would flow from the remedy. An intrusive and draconian remedy based primarily on the outcome of a flawed LOCI screen to address a marginal problem fails the proportionality test.
- (b) **Even if a remedy were necessary, requiring the divestiture of a hospital would be disproportionate.** Given that the CC's own PCA analysis finds no effect of concentration on self-pay prices for Spire, it is manifestly disproportionate to require Spire to divest any hospital. Again, that would be a draconian and intrusive remedy (not to say an unlawful interference with Spire's legitimate property rights) that is not justified by the evidence available and is therefore disproportionate to any competition concern.
- (c) ✗.
- (d) **Requiring any remedy in relation to outpatient and day-case care would be disproportionate.** In its analysis, the CC ignores outpatient and day-case providers as local competitive constraints on the basis that competitive conditions are different in those segments. In fact, the CC concluded that inpatient, day-patient, and outpatient care are distinct product markets. There

is no analysis or evidence as to why the CC's conclusions on in-patient care are relevant to outpatient or day-case care. It is not now open to the CC, as a matter of law, to extrapolate conclusions about competitive outcomes in inpatient care to outpatient and day-case care. Accordingly any remedy imposed can only be limited to inpatient care, and should not touch on outpatient or day-case care.

3. REMEDY 2(A): TYING/BUNDLING – PREVENT BMI, HCA OR SPIRE FROM RAISING ITS PRICES NATIONALLY IF A PMI CHANGED ITS NETWORK POLICY SUCH THAT PATIENT VOLUMES TO THE HOSPITAL OPERATOR CONCERNED WERE LIKELY TO FALL. THIS MIGHT OCCUR IF, FOR EXAMPLE, THE PMI CHOSE TO REMOVE ONE OF THE OPERATOR’S HOSPITALS FROM ITS NETWORK OR IF IT ADDED A RIVAL HOSPITAL TO ITS NETWORK. IN NEITHER CASE WOULD THE PRIVATE HOSPITAL OPERATORS BE ENTITLED TO RAISE ITS PRICES NATIONALLY

Overview

- **No remedy at all is justified: the PFs do not identify any AEC resulting from tying, bundling, or national discount schemes.**
- **The application of the remedy remains wholly unclear and therefore it is difficult for Spire to meaningfully comment on it.**
- **The remedy appears to apply to potential price rises within the context of concluded agreements. If this is the case, the remedy has no connection to Spire’s business: Spire cannot unilaterally raise prices for any reason under the terms of its existing contracts with PMIs.**
- **Spire is concerned, however, that the remedy could be interpreted more broadly. In this case, the remedy would not be reasonable or effective:**
 - **The remedy is based on a series of mistaken assumptions. Where the basis of the CC’s proposed remedy is so factually wrong, the remedy cannot possibly be effective.**
 - **The remedy would not be effective to achieve the CC’s stated aim, as it would likely no longer be feasible for PHPs and PMIs to negotiate at the “national” level. The likely outcome of the remedy would be to introduce “local” pricing (in a more cumbersome and complex way than alternative remedy proposals) and shorter-term contracts (which may not be in the best interests of patients).**
 - **The remedy would be extremely complex to monitor and enforce.**
 - **The remedy is wholly disproportionate. It would risk capturing price rises that have no connection to network changes. It would apply to all forms of treatment, even though the CC’s analysis is limited to inpatient treatment. Moreover, it goes far beyond the concerns expressed by the PMIs.**
 - **The remedy would have significant unintended adverse consequences. It would distort competition – both between hospitals and between PMIs – and put an end to pro-competitive arrangements such as network and volume-based discount policies.**

Introduction

3.1 Spire considers that the CC has no basis (as a matter of law) to impose the proposed remedy. Leaving this aside, the uncertainty attached to the proposed remedy, as currently drafted, makes it difficult for Spire to comment meaningfully on it.

3.2 The proposed remedy states that each of BMI, HCA, and Spire would be prevented from “*raising its prices nationally*” if a PMI “*changed its network policy*” such that “*patient volumes to the hospital operator were likely to fall.*”²¹ However, the application of this principle in practice remains wholly unclear.

3.3 The CC appears to suggest that the proposed remedy would attach to price increases applied within the context of concluded agreements (*i.e.*, to an “*existing agreement*” between a PHP and a PMI).²² That is to say, a PHP would not be able to raise national prices negotiated and agreed at the start of a contract during the course of that contract in the event that a PMI chose to remove one of the PHP’s hospitals from its network or add a rival hospital. If this is the case, the proposed remedy has no connection to Spire’s business: under the terms of its existing contracts with PMIs, Spire cannot unilaterally increase prices for any reason. Pricing provisions affected by national volumes exist only in Spire’s agreements with certain smaller insurers (in which volume-linked discounts are provided to assist these PMIs in winning large corporate accounts). These arrangements are therefore different from the type envisaged by the CC and would fall outside the scope of the proposed remedy on any basis.

3.4 However, because the application of the bright-line rule stated by the CC remains unclear, Spire is concerned that the proposed remedy could be interpreted more broadly:

- (a) First, the rule could be interpreted as providing PMIs with “carte blanche” to unilaterally delist hospitals without facing any of the (mutually-agreed) remedies provided for under contract. (Typically, Spire’s contracts with PMIs are based on a specific network of hospitals agreed at the outset of the contract and delisting one of those hospitals – without good reason – gives rise to a breach of contract.)
- (b) Second, the rule could be interpreted as applying to successive contracts. That is to say, when negotiating at the end of the term of a contract, a PHP would not be permitted to increase its prices in the “new” contract where the PMI proposed to change its network policy from that which formed the basis for the previous contract.

²¹ Notice of Possible Remedies, para. 41.

²² Notice of Possible Remedies, para. 42: “*This variant of the remedy might be appropriate for a PMI that had an existing agreement with a hospital operator and wished to retain these contractual rights but wished to vary the composition of its hospital network*” (emphasis added).

3.5 In light of this uncertainty, and because the specific questions raised by the CC are inter-related (and many of the same observations can be made in relation to more than one of these questions), Spire’s observations on the proposed remedy are set out as follows:

- Section I explains that the CC has no basis (as a matter of law) to impose the proposed remedy.
- Section II explains that the proposed remedy (as interpreted to attach to price rises within the context of concluded agreements) would not be effective *vis-à-vis* Spire, because it bears no relation to the way in which Spire’s business operates in practice.
- Section III explains that the proposed remedy (as given the broader interpretation described in para. 3.4 above) would not be effective, because: it is based on a series of factual errors and mistaken assumptions; it would not achieve the CC’s stated aims; it would be disproportionate; and, it would have several unintended adverse consequences.

I. The CC Has No Basis To Impose The Proposed Remedy

3.6 As a starting matter, the CC simply has no basis (as a matter of law) for seeking a remedy addressing tying, bundling or national volume discounts because the PFs do not identify, reason, or evidence any AEC resulting from tying or bundling by hospital operators, or from national volume discount schemes.

3.7 **The PFs reach no conclusion and contain no material analysis relating to tying and bundling practices.** The PFs, which identify only a single AEC relating to insured pricing,²³ contain no proper analysis or reasoning that connects volume discounts and/or tying/bundling strategies to exclusion of entrants, and therefore to higher insured prices, to the requisite standard of proof.

3.8 Instead, the PFs simply state the “view” that “*the position of a hospital operator in negotiation with PMIs is strengthened when in one or more local areas it operates hospitals that face low levels of competition.*”²⁴

3.9 This assertion is insufficient as matter of law (whether taken as analysis, reasoning, or conclusion) to support the remedy proposed by the CC. Under the *Enterprise Act 2002*, the CC only has the power to seek a remedy where it has found

²³ Provisional Findings at para. 10.3: “*We have identified two structural features in the provision of privately funded healthcare services: (a) high barriers to entry for full service hospitals; and (b) weak competitive constraints in many local markets including central London. Together these features give rise to AECs in the markets 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.*”

²⁴ Provisional Findings, para. 6.290.

an AEC. Since the CC has not identified any AEC resulting from tying, bundling or national volume discounts, it cannot impose a remedy to address those issues.

3.10 Even “second guessing” the CC’s intentions provides no meaningful link between tying/bundling and any AEC. In the absence of any proper analysis of tying/bundling and volume discounts, and in order to inform this part of its response on remedies, Spire has reviewed the rest of the PFs for any possible insight into the CC’s approach.²⁵ However, even this expansive approach provides no suggestion of any AEC resulting from tying, bundling or national volume discounts.

3.11 Any analysis of tying, bundling, and volume discounts is very limited in both nature and scope:

- (a) First, in its discussion of national bargaining in the PFs, the CC noted: *“We did not find that the evidence on bargaining on its own indicated whether hospital operators had market power or that PMIs had buyer power.”*²⁶
- (b) Second, in its outline of its views, the CC noted: *“All the volume discount schemes we have reviewed appear designed to reward the PMI for growing its volume across the whole portfolio of hospitals [...] By rewarding incremental growth relative to total national volumes in this way, the hospital operator creates an incentive to maximise recognition for a given operator and a disincentive to recognise rival hospitals.”*²⁷

3.12 These comments again provide no useful insight. The CC simply notes the schemes it has observed, but advances no evidence concerning the competitive effect of any of these schemes. The CC adduces no evidence suggesting that tying or bundling might give rise to an AEC, *i.e.*, because these discount schemes have prevented efficient entry.

3.13 Although the Notice of Possible Remedies suggests that this remedy is intended to address the CC’s concern that hospital operators may have bargaining power in negotiations with insurers, Spire has also reviewed the CC’s comments on barriers to entry.

3.14 In this regard, the CC notes in the PFs that *“we have found that some large hospital groups may have the ability to induce a PMI to refuse recognition of a new entrant locally, even one offering lower prices or higher quality services”*²⁸. The basis for this conclusion is unclear but appears to be based on two points: (1) A statement by AXA that it decided not to recognise Circle Bath in the context of its broader, national relationship with BMI, including the need to secure agreement over BMI’s participation in AXA’s Corporate Pathways Product (*i.e.*, at a time when AXA

²⁵ The very fact that Spire needs to scour the PFs for insight into the CC’s reasoning demonstrates the inadequacy of the report as a basis for consultation and subsequent decision. Principles of natural justice require that Spire be given a proper and full opportunity to respond to the case against it.

²⁶ Provisional Findings, para. 6.189.

²⁷ Provisional Findings, para. 6.186.

²⁸ Provisional Findings, para. 6.84.

was seeking a discount from BMI); and (2) AXA's general strategy of using selective recognition of hospitals to obtain discounts from PHPs. The context of these examples (*i.e.*, the pursuit by AXA of discounts) further indicates that the CC has not adduced evidence to suggest that any practice relating to tying, bundling or volume discounts has prevented PMIs exercising their bargaining strength on a local or national basis.

3.15 However, even if this remedy were designed to address barriers to entry (and there is no suggestion that this is the case in the Notice of Possible Remedies), the CC has not set out any basis to conclude that a remedy relating to national prices would reduce any barrier to entry.

3.16 **The absence of any meaningful analysis/reasoning on tying and bundling precludes any remedy and violates the CC's legal obligation to properly reason its decisions.** In sum, the CC has not set out any basis to impose the proposed remedy. Indeed, because of the inadequacy of the PFs, Spire cannot properly address the effectiveness of the proposed remedy. The CC has not provided any analysis or reasoning explaining why it is necessary to address tying, bundling or national volume discounts in the market. The CC has a legal obligation under section 136(2) of the *Enterprise Act 2002* to disclose properly its reasons for its decisions. However, reasoning supporting the proposed remedy cannot be discerned from the PFs. In the absence of such reasoning, Spire cannot reasonably be expected to respond to an unknown case.

II. The Proposed Remedy (As Applied To Concluded Agreements) Would Not Be Effective Vis-à-vis Spire

3.17 As noted above, the CC appears to suggest that the proposed remedy would apply to price increases proposed within the context of concluded agreements (*i.e.*, to an "*existing agreement*" between a PHP and a PMI). Under this interpretation, a PHP would not be able to raise national prices negotiated and agreed at the start of a contract during the course of that contract where a PMI chose to remove one of the PHP's hospitals from its network or add a rival hospital. If this is the case, the proposed remedy has no connection to Spire's business.

3.18 **Spire's contracts with PMIs do not allow it to unilaterally increase prices.** Spire does not have any contracts with PMIs that allow it to immediately change its national pricing in response to a change in the PMI's network strategy. ✂. Spire is therefore already unable to increase its national pricing to PMIs in response to a change in a PMI's network strategy. The proposed remedy would therefore have no effect *vis-à-vis* Spire.

3.19 ✂.²⁹

3.20 ✂.

²⁹ ✂.

3.21 In sum, therefore, the proposed remedy (as interpreted to apply to price increases made within the context of concluded agreements) would be of no relevance to Spire, and therefore Spire has no comment on whether this would be a reasonable and effective remedy. Spire simply notes, however, that the proposed remedy could prevent the clearly pro-competitive arrangements \times .

III. The Proposed Remedy (As Interpreted More Broadly) Would Not Be Effective

3.22 As noted above, the scope of the proposed remedy, as currently drafted, remains unclear and Spire is concerned that this bright-line rule could be interpreted more widely, in particular in two ways: (1) as preventing PHPs from enforcing their mutually-agreed contractual rights if a PMI were to delist a hospital during the course of a contract; (2) as applying to successive rounds of contracts between PHPs and PMIs.

3.23 In either case, as explained below, the proposed remedy would not be reasonable or effective for several reasons and is therefore unlawful.

A. The Proposed Remedy Is Based On A Series Of Factual Errors And Mistaken Assumptions

3.24 In deciding whether to impose any remedy, the CC must show that the specific remedy that is proposed would have the effect of remedying the AEC identified. However, the proposed remedy fundamentally misunderstands how the marketplace operates in practice and is based on a series of significant factual errors or mistaken assumptions. Where the basis of the CC's proposed remedy is so factually wrong, that remedy could not possibly be effective.

3.25 **The proposed remedy wrongly assumes that national prices are arrived at by simply "adding up" local volume discounts.** The general principle that underpins the proposed remedy – that a PMI should be unilaterally permitted to delist certain hospitals in a mutually-agreed network without any change in national pricing – appears to rest on the assumption that national prices are simply an aggregation of volume discounts across a group of hospitals. In this way, the CC appears to suggest that it would always be economically viable for a hospital provider to retain those discounts at its remaining hospitals were a PMI to delist one or more of its other facilities or services. However, this is not correct.

3.26 Spire's pricing to PMIs reflects the inclusion of a broad basket of services in that contract (with costs varying between facilities and specialties). National prices can also reflect the fact that many of the costs in Spire's hospitals are shared across specialties.³⁰ If one of the specialties that makes use of a shared service is removed,

³⁰ As stated in Spire's response to the Market Questionnaire: "*the financial viability of hospitals typically depends on offering patients a basket of products. The provision of a basket of products supports the efficient use of resources: a hospital may not have a sufficient base of potential hip replacement patients to support a theatre with laminar flow, but may be able to support that theatre with a combination of hip replacement and other orthopaedic patients. At a more general level, 'cherry picking' services results in the removal of a stream of patients whose payments contribute to the overhead base of the hospital, leaving the hospital with a smaller base of patients*

it may not be economically viable to continue to operate that shared service at that facility.³¹ In some cases, national pricing can also be used to enable the introduction of new specialities by spreading risk across a wider portfolio of hospitals. For example, if one specialty at a hospital does not receive the necessary volume in the short-run, a degree of “cross-subsidisation” across the portfolio may allow Spire to continue to operate that specialty until it reaches a critical mass.

3.27 The proposed remedy ignores that there are several reasonable grounds to support price increases where a PMI reduces its volume of business. Given the variety of factors assessed in negotiating volume discounts, there are several grounds on which Spire might reasonably seek a price increase from a PMI if it reduced the amount of business it did with Spire. For example, if a PMI were to shift a particular service away from Spire, that change could affect the cost base for other services within the hospital network and reasonably lead to a price increase for those other services.

3.28 Indeed, as a practical matter, most changes to a PMI’s network policy are likely to result in a decrease in patient volumes for a PHP. ✕. However, under the terms of the proposed remedy, Spire would be prevented from changing its prices to address this change in its economic situation.

3.29 The proposed remedy incorrectly assumes that hospital operators are able to rely on less substitutable hospitals in negotiations to raise prices for every hospital in their portfolio. This is an extraordinary assumption given that there is no evidence in the CC’s Provisional Findings that prices negotiated with insurers are above the competitive level at less substitutable hospitals. There is no basis on which the CC can conclude that a remedy that is likely to effectively drive down prices at such hospitals would be effective or efficient. To the extent that the CC’s Provisional Findings suggest that a hospital operator may be able to charge prices to PMIs above the competitive level, a suggestion which Spire has strongly refuted in its PF Response, this suggestion is limited to an aggregate effect across a basket of products and across the operators’ entire portfolio. Given the small price differential between Spire and those PHPs that the CC has concluded do not have market power, to extrapolate that even the prices at Spire’s highest quality hospitals were above the competitive level would require an extraordinary assumption.

through who to cover its services. Removal of recognition by a large insurer would threaten the viability of some services, and the loss of particular service lines could threaten the viability of an entire hospital.” See Spire’s response to market questionnaire at para 43.2(c).

³¹ For example, Spire’s business plan for cancer services indicates that the imaging and surgical services associated with its cancer services rely on non-cancer work to achieve the volumes required for a minimum efficient scale (see 001-006-9991-0444). Similarly, the GMC establishes guidelines on the minimum number of particular procedures that should be done each year. If a PMI were to delist a procedure at Spire, it might no longer be possible to safely continue that procedure, and discontinuance of the procedure could affect the viability of other services in the hospital.

B. The Proposed Remedy Would Not Be Effective To Achieve The CC's Stated Aims

3.30 **The proposed remedy would not prevent tying, bundling, or national volume discounts but just introduce a one-sided prohibition to prevent PHPs from enforcing such provisions.** As currently drafted, the proposed remedy appears to assume that PHPs and PMIs would continue to enter into longer-term national pricing arrangements, even though the PMIs would effectively be able to unilaterally alter the terms of that contract (without PHPs being able to make any price changes or take any other form of contractual recourse). Or, in other words, national pricing would continue but without clauses that would allow PHPs to respond to the delisting of a hospital within the agreed network.

3.31 This is not a feasible outcome because:

- (a) National prices are set to ensure that costs are reimbursed on average across a portfolio of hospitals which vary significantly with respect to cost structure and patient mix. The removal of one or more facilities would have repercussions for the average cost and patient mix across the remaining hospitals, and would necessarily require the national price to be adjusted simply to ensure adequate cost recovery.
- (b) In a high fixed-cost business such as private healthcare, there is an incentive to discount to win additional volumes. As Spire has typically negotiated a single treatment price applicable at all its hospitals for a given PMI, it has offered discounts on this single price in return for anticipated volumes across its entire portfolio of hospitals. If Spire can no longer expect to have access to a PMI's volumes for a number of its facilities, it will lose its existing ability to spread the fixed costs at these facilities. Spire and the PMIs will then need to look for alternative means to reflect improved fixed-cost coverage at the selection of facilities where it can anticipate higher volumes.

3.32 **The proposed remedy would result in PHPs and PMIs moving to shorter-term local pricing.** Given the inherent uncertainty around any "national" contract if the proposed remedy were to be introduced, PHPs and PMIs would no longer be able to rationally negotiate pricing terms at the national level. A probable outcome would therefore be a move to shorter-term local pricing arrangements.

3.33 There are potential benefits to a local pricing structure, but it does not seem sensible to construct the remedy as a ban on tying, bundling, and national volume discounts particularly when more reasonable and effective alternatives – such as Remedy 2(b) – are available.³²

3.34 A move away from longer-term contracts would undermine the stable basis required for PHPs and PMIs to work together to develop innovative healthcare delivery arrangements, and would therefore ultimately disadvantage patients. Indeed, in order to avoid the uncertainty that the proposed remedy would entail, it could even

³² There is some evidence that the market may already be moving in this direction. ☒.

be the case that the private healthcare market would ultimately end up operating as a “spot” market (with pricing determined *ad hoc* on a case-by-case basis). Given that this would reduce the certainty and foreseeability around pricing, this might again not be in the best interests of patients.

3.35 The proposed remedy would be complex to implement and monitor. There is no doubt that the proposed remedy would be extremely complex to monitor and enforce.³³ In particular:

- (a) **Monitoring.** The proposed remedy would seem likely to require a particularly extensive and intrusive monitoring regime. If, for example, the proposed remedy were interpreted as applying to successive rounds of contracts between a PHP and a PMI, would the monitor somehow “referee” ongoing contractual negotiations in order to determine whether proposed pricing changes were justified or not?
- (b) **Causation.** The monitor would be required to adjudicate on complex questions of fact and law. It is unclear, based on the information provided at present, how the monitor would distinguish between legitimate price rises and rises due solely to changes to network policies.³⁴ It seems certain that these could be complex and fact-intensive assessments that would occupy significant time and resources, and could not be accommodated during contract negotiations.
- (c) **Knock-on commercial uncertainty.** Even if the validity of pricing provisions could be monitored effectively, the proposed remedy could still result in considerable commercial uncertainty. In the event that a provision were considered to be unenforceable, it may not be clear whether that provision could be severed or whether the entire contract would then be unenforceable. Resolving this question might require negotiation and/or litigation between the parties before the ordinary courts (following the separate review of the provisions within the scope of the proposed remedy). This would create cost and uncertainty for Spire and other market participants.

C. The Proposed Remedy Is Disproportionate

3.36 It is remarkable that the CC seeks to apply any remedy whatsoever where there is no evidence of any AEC. This is, in itself, disproportionate and unlawful.

³³ In its Response to the Notice of Possible Remedies, Aviva also noted this concern: “*This remedy is also likely to require significant levels of monitoring and enforcement to be effective. We would expect that disputes between hospital operators and PMIs on whether a given price increase was in breach of this remedy would have to be resolved by the OFT or a third party. However, it will be difficult for a third party, even one with considerable knowledge of the private healthcare market, to determine whether a price increase in commercial negotiations between a hospital operator and a PMI should be permitted or prohibited*” (see p. 6).

³⁴ In its Response to the Notice of Possible Remedies, Aviva also noted this concern: “*...It’s not clear what conduct the CC proposes would fall under this prohibition and how the remedy would distinguish between legitimate price increases by hospital operators driven by increases in costs and prohibited price increases driven by changes in PMIs’ network policies*” (see pp. 5-6).

Moreover, even if the CC had established an AEC concerning tying, bundling or national volume discounts, the remedy that has been proposed by the CC is disproportionate on several bases, not least because if the aim is to address alleged market power held by Spire, that aim is misconceived. As explained in Spire's Response to the PFs, the CC has no basis to conclude that Spire has market power in "national" negotiations. In addition, the specific proposed remedy is disproportionate for several reasons:

- (a) **The proposed remedy would apply to all pricing changes, even if not related to changes in network policy.** The proposed remedy purports to address a concern regarding "national" volume discount schemes when a PMI removes one of the PHP's hospitals or adds a rival hospital to its network. However, the application of the remedy would be far wider. This is partly of course because there is no such thing as a truly "national" contract since no PHP actually has national coverage. The proposed remedy would apply to any pricing changes introduced by a PHP (whether or not those price changes are connected to a national volume discount) in response to any changes in a PMI's network policy that were likely to result in a decrease in patient volumes.
- (b) **The proposed remedy would apply to all forms of treatment, even though the CC's analysis is limited to inpatient treatment.** Even if the CC had found an AEC relating to tying, bundling or national volume discounts, it could only have found such an AEC with respect to inpatient treatment, since its assessment did not extend to day-case or outpatient treatment. The proposed remedy is therefore too broad because it would also apply to day-case and outpatient treatment.
- (c) **The proposed remedy is disproportionate to the concerns identified by the PMIs.** The CC's proposed remedy is even disproportionate to the potential concerns expressed by the PMIs:
 - (i) The concern expressed by Bupa was not that a hospital operator could increase its prices in response to a reduction in volumes, but rather that a hospital operator could increase its prices disproportionately in response to a reduction in volumes. Bupa explained that, if prices at other hospitals were increased substantially, it might not be worthwhile for a PMI to exclude a hospital.
 - (ii) Bupa's statements implicitly recognise that there are appropriate grounds on which a hospital operator might seek some price increase in response to a decrease in the volume of patients from a PMI.
 - (iii) The remedy proposed by the CC is therefore disproportionate to the concern expressed by Bupa. In reality, the only way in which the CC's proposed remedy could work is by preventing PHPs from introducing any price increase – this would be manifestly disproportionate.

D. The Proposed Remedy Would Have Several Unintended Adverse Consequences

3.37 As established in the CAT's case law, any remedy imposed by the CC should not propose adverse effects that are disproportionate to the aim pursued by that remedy.³⁵ The proposed remedy would fail this test because a number of adverse effects would arise.

3.38 **The proposed remedy would distort competition.** The remedy would allow a PMI to negotiate a price across the entire portfolio and then "cherry pick" its network to include only the highest quality and/or highest cost hospitals. As a result, PMIs could end up paying a price below the competitive level for high-cost high-quality hospitals (*i.e.*, because the lower-cost lower-quality hospitals in the network, which could be "dropped" by PMIs after entering into a contract, typically serve to lower the "average" national price arrived at during negotiations). This could lead to a distortion of competition for high cost-high quality hospitals (with the PMI paying a sub-competitive price at higher quality hospitals) and weaker hospitals falling out of the mix completely. This could easily lead to a shrinking of hospital networks, reduced incentives to invest in new treatments and quality improvements, a reduction in choice for patients in some areas of the country, and a loss of competition in some areas.

3.39 **The proposed remedy would effectively preclude efficient volume-based discounting.** The principle of offering lower prices in return for higher volumes – as with the use of restricted networks by PMIs – is a basic commercial proposition. In principle, a PHP should be able to benefit from economies of scale. However, the proposed remedy would effectively prevent both PHPs and PMIs from benefiting from rational commercial negotiations founded on efficient volume-based discounting at the national level.

3.40 **The proposed remedy could put an end to pro-competitive restricted network policies.** The proposed remedy would also undermine the PMIs' current restricted networks policies. The CC has acknowledged that restricted networks are a way for PMIs to receive lower prices by offering quasi-exclusivity (and hence the expectation of greater volumes). A PHP could not rationally offer a lower price to participate in a restricted network if the PMI was not then bound by the contract establishing the network. At present, a PHP may bid to participate in a restricted network because of the uplift in patient volumes associated with quasi-exclusivity. If this benefit of the network (and the associated discount) cannot be relied upon, the efficacy of restricted networks will be called into question. Put simply, the incentive to offer a discount to a PMI to be part of a quasi-exclusive network would be very substantially reduced.

³⁵ In its decision in *Tesco plc v Competition Commission* [2009] CAT 6, the CAT states that a remedy "*in any event must not produce adverse effects which are disproportionate to the aim pursued*" (para 137).

3.41 **The proposed remedy would restrict competition between PMIs.** Currently, PHPs provide extra discounts to PMIs to help them to win new business or retain particular accounts. ✂.³⁶

(a) 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?

3.42 See above (in particular paras. 3.30-3.35).

(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?

3.43 It is difficult for Spire to respond meaningfully to this question given the uncertainty around the CC's proposal.

3.44 ✂. Spire considers that the remedy should therefore be introduced upon the expiry of existing contracts with these PMIs. The delay associated with phasing in changes after the end of the current contracts would not be unreasonable.

3.45 If the proposed remedy would apply more broadly (as described in para. 3.4 above), its implications would be far more extensive.

- (a) In this case, the proposed remedy would affect all of Spire's contracts, as any change to a PMI's network policy would fall within the scope of the proposed remedy.³⁷
- (b) The proposed remedy would have a material impact on existing contracts (*i.e.*, because doubts would immediately arise around the legality of certain provisions in existing contracts and it seems that PMIs might effectively be able to unilaterally alter existing agreements).
- (c) In practice, the introduction of the proposed remedy would effectively rescind all existing agreements and require them to be immediately renegotiated.
- (d) As noted above, the introduction of the proposed remedy would likely result (at least for Spire) in the introduction of individual pricing for its hospitals and services. While the costs attached to the introduction of individual pricing would not be prohibitive, the work involved means that the rapid and sudden implementation of the proposed remedy would be impractical and ill-advised.

³⁶ ✂.

³⁷ For example, where Spire has entered into a contract with a PMI following a tender for a restricted network (assuming that a contract for a restricted network is a "national" contract for these purposes), the pricing provided by Spire under that agreement was negotiated on the basis of the cost structure and patient mix of that network. However, the proposed remedy appears to allow the PMI to change the structure of the restricted network (and therefore the cost structure and patient mix relevant to the national price agreed) while denying Spire its contractually-agreed recourse to adjust prices accordingly.

3.46 The broad implications of the proposed remedy mitigate against immediate implementation. Spire considers that the remedy could only be introduced upon the expiry of existing contracts with PMIs (where the contracts have a fixed expiry date) or after at least 12 months (for “evergreen” contracts).³⁸ This would allow both parties to the contract to give weight to the impact of the proposed remedy during bargaining. The delay associated with phasing in changes after the end of the current contracts would not be unreasonable.

(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?

3.47 See above (in particular paras. 3.27-3.28).

(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?

3.48 See above (in particular para. 3.35).

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

3.49 Given the uncertainty attached to the proposed remedy, as currently drafted, Spire is unable to comment meaningfully this question.

³⁸ ✂.

4. REMEDY 2(B): REQUIRE BMI, SPIRE AND HCA TO OFFER AND PRICE THEIR HOSPITALS SEPARATELY

Overview

- **No remedy at all is justified: the PFs do not identify any AEC resulting from tying, bundling, or national discount schemes.**
- **Despite this, the remedy could be implemented without material practical difficulty (indeed, it reflects a business model that is already in place to some extent).**
- **The proposed remedy would represent a material variation to Spire’s existing arrangements with PMIs and some time would be required to transition to new arrangements. The remedy should therefore only be implemented upon the expiration of existing contracts. Should the CC seek to apply the remedy to existing contracts, sufficient time (at least 12 months) should be provided prior to introduction to allow for existing contracts to be renegotiated.**

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

4.1 As noted above (and explained in detail in the PF Response), Spire considers that there is no basis for any remedy whatsoever because the PFs do not identify any AEC from tying or bundling by hospital operators to the required legal standards.

4.2 While no remedy at all is necessary or justified, in response to the question raised by the CC, Spire considers that the proposed remedy would be “*practicable*” in that a measure of the type proposed by the CC – *i.e.*, to “*require BMI, Spire and HCA to offer and price their hospitals separately and individually to PMIs*” – could be implemented without material practical difficulty. Both PHPs and PMIs would need to invest some time and resources in establishing the initial set of individualised prices, but that process would be relatively straightforward and the incremental costs thereafter would likely be limited.

4.3 At present, Spire negotiates national prices with PMIs for each of the treatments offered at its hospitals. Spire’s current negotiations with PMIs therefore establish national price levels for thousands of different treatments. ✕.

4.4 In practice, the starting point for any negotiation is the existing price. In the typical course of negotiations, a “general” price change is agreed across the entire basket of treatments and facilities, with more “specific” prices agreed for a smaller subset of those treatments (*i.e.*, a PMI will usually have identified a particular subgroup of treatments for which it is seeking a lower price, and Spire may have identified a group of treatments for which it is seeking a higher price). If the proposed remedy is introduced, Spire anticipates that the negotiation of local prices/discounts will likely proceed in a similar fashion.

4.5 Spire considers that its own business systems would generally be able to accommodate a move to local pricing, albeit with some adjustment.³⁹

4.6 One practical solution to implementing this remedy may be for a PMI and PHP to negotiate a national “standard rate” (*i.e.*, for all procedures, codes *etc.*) for each of a hospital group’s services, and then negotiate variations (*e.g.*, discounts) from that rate for particular hospitals as is deemed appropriate by both parties. Such an approach would reduce the administrative burden, while still achieving the aims of the remedy. For the avoidance of doubt, the proposed remedy should not require PMIs to negotiate with individual hospitals. Negotiations could continue to be run centrally and therefore the transaction costs around the proposed remedy should not be excessive.

(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?

4.7 The proposed remedy would require material changes to Spire’s existing arrangements with PMIs. Considerable time and resource would have to be invested in establishing new prices, negotiating new or revised agreements with PMIs, and adjusting Spire’s business systems.⁴⁰ While the costs of implementation are not prohibitive, the work involved means that the rapid and sudden implementation of the proposed remedy would be ill-advised. Given the scope of work involved, and in order to avoid any potential adverse effects for patients, the proposed remedy could only be implemented upon the expiration of Spire’s existing contracts with PMIs. The delay associated with phasing in changes after the end of the current contracts would not be unreasonable. In the case of contracts with no fixed expiry date, sufficient time – *i.e.*, at least 12 months – should be provided prior to introduction to allow existing contracts to be renegotiated.⁴¹

³⁹ For example, although the proposed remedy would increase the number of different prices Spire needed to track in its IT systems, these systems are fully capable of coping with these additional variables.

⁴⁰ For example, by updating pricing information in order to allow Spire to bill services to PMIs individually by hospital.

⁴¹ At the very least, Spire considers that the lead time for the internal administrative changes necessary to implement the remedy – such as systems alteration and staff training *etc.* – would be likely to amount to at least six months.

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

4.8 Unlike Remedy 2(a), Remedy 2(b) directly addresses one of the CC’s provisional findings, and an issue identified in the CC’s conclusions on insured price outcomes. Although there was no evidence in the PFs that any of the hospital operators leverage certain of their hospitals to obtain higher prices across other hospitals in their portfolio, this appears to be a concern for both the CC and some of the PMIs. The proposed remedy, by decoupling the hospitals in a PHP’s portfolio, would prevent the introduction of such a strategy.

4.9 As a starting matter, Spire disagrees with the CC’s suggestion that any of its facilities operates in a so-called “Single hospital area.” Spire considers that all of its hospitals are subject to a range of competitive constraints, including from facilities in other geographic areas, outpatient and day-case providers, and the NHS (both PPU and NHS hospitals).

4.10 A number of other factors suggest that price increases would not occur in single hospital areas (unless justified by the underlying cost position of the hospital):

- (a) First, single hospital areas often arise due to low PMI penetration in certain areas, which may limit the level of demand for private hospital services. An area with low demand for private healthcare services is not of great importance to a PMI. PHPs face a greater threat of delisting in such areas because a PMI would have to require only a small number of patients to travel further, disciplining these facilities even in the event that they do not have an alternative proximate private facility. There is therefore no reason to presume that prices would rise in these areas, and may in fact fall.
- (b) Second, as explained in more detail below, increased prices in Single hospital areas that were not justified by underlying costs would be likely to elicit new entry (assuming sufficient PMI penetration).
- (c) Third, as explained in Spire’s PF Response, the CC’s assessment of consumer benefits relies on an unsubstantiated assumption that PMIs pass on the benefits of discounts to consumers. Few (if any) PMIs currently offer differentiated premia based on location. Accordingly, even if the prices charged by PHPs were to rise in Single hospital areas, it cannot simply be assumed (in the absence of any analysis or evidence) that PMIs would raise consumer prices locally. If PMIs did pass on local price increases directly to the customers in that area, the loss of insurance subscribers likely to result from a PHP price increase would limit a PHP’s incentive to raise prices in the first place.⁴²

⁴² Bupa has suggested that increases in premia levels result in a significant loss of insurance subscribers (both new subscribers, and existing subscribers at the point of renewal). In the event that a PHP were to increase its prices at a local facility, and assuming that an increase in prices would result in an increase in premia charged to local residents for health insurance, this would, according to Bupa, lead to a significant loss in PMI volumes through a loss of lives insured.

(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 hospital's catchment areas?

4.11 As a starting matter, it is not necessarily the case that prices will rise in Single hospital areas. Instead, as explained above, in areas of limited demand (including Single hospital areas) prices may in fact fall. Accordingly, it is not correct to simply assume that prices will rise in Single hospital areas if hospital providers and PMIs move away from national pricing.

4.12 If prices increased in Single hospital areas, new entry would be an entirely likely outcome (unless price increases were justified on the basis of underlying cost), assuming sufficient PMI penetration.

4.13 There are no insurmountable barriers to entry in the UK. This view is supported by the significant evidence of recent entry and expansion. In an effort to further lower barriers to entry, the CC has also proposed a remedy relating to the operation of PPUs by incumbent hospital operators.

4.14 Where a local area is large enough to support multiple facilities, then that area is contestable and an exercise of market power by a local operator would be expected to create enhanced opportunities for entry. Even where local demand is likely too low to stimulate PHP entry, a PPU could nevertheless enter (often by taking advantage of existing NHS facilities in that area).

4.15 Even short of a private operator immediately entering the market with a full service private hospital, there are several ways in which entry could occur in a local area, each of which could have a significant effect on Spire's hospitals.

- (a) The NHS could develop a private patient offering. The NHS is typically able to develop such facilities at relatively low cost given its existing infrastructure. This kind of entry already occurred in several of the CC's areas of potential concern, such as the Wirral. In addition, the CC has recognised the removal of the private patient cap as a factor that may lead to greater NHS activity in the private sector in the future.
- (b) A new entrant could open a day-case or outpatient facility, and expand into inpatient care. This has already happened or is expected to happen in several other areas identified by the CC as being of potential concern, such as Cardiff and Edinburgh. Spire generates the majority of its revenues from outpatient and day-case treatment, and therefore the loss of this business can have a significant effect on its hospitals.
- (c) An existing provider may decide to widen its catchment area by establishing a satellite facility in the area in an attempt to draw patients to a facility located at a somewhat greater distance (as Spire itself has done in numerous local areas).
- (d) Finally, just because a rival hospital is not within a certain drive time of a so-called Single hospital does not mean that *patients* lack choice; indeed, an

important share of patients in Single hospital areas will typically have access to rival hospitals.

4.16 There is, therefore, no indication that local pricing would serve as a barrier to entry, even in Single hospital areas. Indeed, national pricing may in fact currently be acting as a deterrent to entry by suppressing local price levels. Potential entrants cannot easily identify high value areas for entry because regional variations are masked by the national price. If prices were to vary between hospitals, this could create more targeted opportunities for new entrants.

(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?

4.17 Consumer detriment would arise if the proposed remedy were to lead Spire to close one or more of its hospitals. Broadly speaking, any remedy that could increase the likelihood of a major PMI delisting one or more of Spire’s hospitals would increase the likelihood of Spire closing those hospitals. Delisting is likely to have a serious impact on the profitability of a hospital (as evidenced in Spire’s Paper on Bargaining). The CC has recognised in its PFs that delisting can have a significant effect on a hospital operator.⁴³ Indeed, as Spire stated in its response to the Annotated Issues Statement: *“Delisting even a single hospital is a significant threat because it would undermine the financial viability of that hospital.”*⁴⁴ However, delisting one or more of Spire’s hospitals is already a viable option for PMIs today, and it is not clear that the proposed remedy would increase the likelihood of this.⁴⁵

4.18 Consumer detriment would also arise if the proposed remedy were to lead, in areas with more competitors, to a “race to the bottom” in which PMIs sought to direct patient volumes to the lowest cost hospitals, and hospitals, in turn, focused on competing solely on price (rather than quality and innovation). It is not clear whether the proposed remedy would increase the likelihood of a “race to the bottom” in these areas. This risk could, of course, be offset by allowing hospitals to charge top-up fees for access to “higher quality” hospitals. This would not only optimise patient choice, while allowing PMIs to manage their own costs effectively, but also create opportunities for hospital providers to develop tiered services, and to offer a premium service to patients in areas with sufficient demand.

⁴³ Provisional Findings, para. 169.

⁴⁴ See Spire’s Response to the Annotated Issues Statement, para. 4.10.

⁴⁵ ✂.

(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?

4.19 The proposed remedy restricting arrangements between hospitals and consultants should alleviate any concern that incumbent hospitals could enter into arrangements with consultants that would prevent or deter them from practising at an entrant's hospital.

5. REMEDY 3 – PREVENT THE OWNER OF A HOSPITAL IN A SINGLE OR DUOPOLY AREA FROM PARTNERING WITH AN NHS TRUST TO OPERATE A PPU

Overview

- **No remedy at all is justified: the PFs do not identify any AEC to the requisite legal standard.**
- **Notwithstanding the requirement for any remedy at all, preventing hospital operators from partnering with local NHS Trusts to operate PPUs would likely create additional opportunities for entry by new providers to a given geographic area.**
- **However, an NHS Trust should be permitted to partner in a PPU with an incumbent operator where no other operator can be identified within a reasonable time period.**
- **The remedy would only operate effectively if it provides a clear and serviceable framework for NHS Trusts and private operators.**
- **Effective monitoring would also essential; an efficient and practicable approach may be to specify that the acquisition of a PPU contract is a relevant merger situation under the Enterprise Act 2002 and therefore subject to merger control review (where the applicable thresholds are met).**

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

5.1 There is no basis for any remedy whatsoever because the PFs do not establish any AEC to the requisite legal standard. However, leaving aside the lack of evidence to support any remedy, the measure proposed (*i.e.*, to prevent hospital operators from partnering with their local NHS Trusts to operate PPUs) would provide PHPs that are not active in a given local area with additional opportunities for entry.

PPUs are already being launched in several areas of concern and this trend is likely to continue

5.2 The removal of the private patient income cap under the Health and Social Care Act 2012 has led to a significant number of NHS Trusts exploring opportunities to generate additional private revenues, including through PPUs. Given the developments that are already underway (some of which are described below), Spire disagrees with the CC's suggestion that "*the lifting of [the] cap is unlikely to give rise to such significant expansion that PPUs will operate as substantially greater competitive constraint on private hospital operators in the near future.*"⁴⁶

⁴⁶ Provisional Findings, Appendix 3.1 at para. 26.

5.3 PPU have recently opened or are being developed in \mathcal{R} . Recent examples include:

- (a) A new private cancer centre, the Clatterbridge Clinic, opened in Wirral in June 2013 providing chemotherapy and radiotherapy services. This centre is a partnership between the Clatterbridge Cancer Care NHS Foundation Trust and Mater Private Healthcare. A new facility across Arrowe Park and Clatterbridge – for a full range of private services – is also understood to be under development. (In its local areas working paper, the CC described Spire Wirral as facing insufficient constraints in a multi-provider environment.)
- (b) Ramsay has been awarded the contract to operate the Addenbrookes PPU in Cambridge. This is a significant facility, consisting of 64 in-patient beds and five theatres.⁴⁷
- (c) The Royal Derby Hospital has announced that it will be opening a new private patient ward providing inpatient services in October 2013.⁴⁸ (The CC has identified the Nuffield Derby hospital located 1.8 miles away as a solus facility in its local areas working paper.)
- (d) The Poole Hospital opened the new Cornelia Suite for private patients in October 2012. The Cornelia Suite offers bariatric surgery, cardiology, endoscopy, general surgery, gynaecology, orthopaedics, paediatrics, maxillo-facial surgery, and ENT surgery, as well as a variety of outpatient services.⁴⁹ (The Cornelia Suite is located 6 miles from the Nuffield Bournemouth Hospital and 0.2 miles from the BMI Harbour Hospital, which the CC characterised as being in a symmetric duopoly in its local areas working paper.)
- (e) Several NHS trusts – including Southampton City, Stanmore, Wythenshawe, Wrightington, Barts, Guy’s and St. Thomas’, and St George’s – are in the middle of formal procurement processes for commercial development partners, elements of which are for private hospitals.

5.4 Spire anticipates that the trend of NHS facilities seeking to expand their private patient offerings will continue and that there will be significant opportunities for private operators to partner with NHS Trusts to operate PPUs in the future. Income from private patient procedures rose by 12% in English NHS hospitals in 2012-13 and is forecast to rise by a further 10% over the next 12 months.⁵⁰

⁴⁷ See <http://www.cuh.org.uk/cms/corporate-information/about-us/our-future/forum/private-hospital>.

⁴⁸ See <http://www.derbyhospitals.nhs.uk/about/latest-news/?entryid22=49139>.

⁴⁹ See <https://www.poole.nhs.uk/about-us/latest-news/2012-news-archive/new-private-patient-suite-open.aspx>

⁵⁰ See <http://www.healthinvestor.co.uk/ShowArticleNews.aspx?ID=2964>.

The proposed remedy would only be effective if it provides clarity and certainty to NHS Trusts and Private Operators

5.5 The proposed remedy would only operate effectively if it provides a clear and serviceable framework for NHS Trusts and private operators. Accordingly, it must be possible for NHS Trusts and private operators to determine:

- (a) Whether one of the private provider's hospitals is operating in the same geographic area as the proposed PPU; and
- (b) Whether an existing private hospital is a Single or Duopoly hospital.

5.6 If NHS Trusts and private operators cannot make these assessments, they will not be able to identify which private hospitals are eligible to bid to participate in a PPU partnership. If NHS Trusts and private operators cannot determine which operators are eligible to operate a PPU, it is not clear how the NHS could run an effective bidding process for a new unit (or re-tender an existing unit).

5.7 Assuming that the remedy is intended to operate within specific geographic markets, geographic boundaries of some sort must be identified for the scope of the remedy (in order for the remedy to be intelligible and practically applicable). These boundaries cannot be linked to LOCI because of the associated legal uncertainty: both the NHS Trust and the candidate would lack sufficient information to conduct a LOCI analysis to determine whether or not particular hospital operators are eligible to operate a proposed PPU. (Moreover, as explained in the PFs Response, the LOCI is misconceived as a measure of competitive intensity in any case.)

5.8 It is wholly unclear from the CC's analysis how far away a private operator's hospital would need to be from a proposed PPU in order for the private operator to be eligible to partner in the PPU. The adoption of a standard geographic radius, based on the average of the market sizes the CC has identified across the UK, seems a sensible approach.⁵¹ Such an approach would allow NHS Trusts to identify potential partners, and minimise the risk of a reduction in competition resulting from the partnership.

5.9 A similar difficulty would arise for a private operator or the NHS in determining whether a hospital might be a Single or Duopoly hospital. This is not a straightforward exercise to undertake for an NHS provider. For example, even hospitals facing more than one competitor have been identified as Duopoly hospitals in the CC's analysis.⁵² A universal standard, not relying on LOCI, for identifying Single and Duopoly hospitals must be developed in order for the remedy to be workable.

⁵¹ Spire expects that some form of adjustment might be required for the London given the specific nature of that area.

⁵² For example, in its local area working paper, the CC identified Nuffield in Bristol and the BMI Bath Clinic as competitors exercising a constraint on Spire Bristol, but described Spire Bristol as a Duopoly hospital.

5.10 The CC should also clarify whether the reference to a “PPU” is intended to include all NHS private provision. There are multiple forms of private provision in the NHS, and what is considered to constitute a “PPU” can also vary.⁵³

5.11 Finally, the CC should clarify the circumstances in which an incumbent might be eligible to operate a new PPU. As explained in response to Question 3(d) below, the proposed remedy could be framed to permit an NHS Trust to partner with an incumbent operator in a PPU where no other operator could be found within a reasonable time period. The CC should also clarify whether an incumbent might be eligible in certain other circumstances, including for example: (1) if the PPU services are not those delivered at its existing hospital;(2) if the incumbent intends to close its existing facility and relocate to the trust; or (3) if the incumbent’s only existing facility is a “management contract” type arrangement (typical of early PPU arrangements).

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

5.12 Hospital operators would typically be well-placed to form PPU partnerships in areas where they did not already operate a hospital. As explained in Spire’s response to the PFs, barriers to entry in the UK are not insurmountable, even for an operator seeking to develop a new facility. Partnering with the NHS would further lower any possible barriers to entry and make entry into the area easier:

- (a) **PPUs are well-placed to attract patients from incumbents.** A new PPU is likely to be well-placed to attract patients from incumbents. Most patients are referred to a private hospital or consultant by a GP and the most GPs refer the majority of their patients for NHS rather than private treatment. GPs would be expected to be familiar with the existing NHS facility and to have an established history of referring patients to that facility, which may encourage the GPs to refer patients to an associated private facility.
- (b) **PPUs are well-placed to attract consultants.** The CC has expressed concern that arrangements between private healthcare providers and consultants may deter or prevent consultants working with a new entrant. The NHS Trust is likely to be the primary employer of any consultant working in its PPU and, as such, would be well-placed to recruit consultants to work in the facility.
- (c) **PPUs typically have lower set-up costs.** The cost of designing, building and equipping a PPU to provide a full range of inpatient, day-case and outpatient facilities can be lower than the cost of designing, building and equipping a stand-alone private hospital. PPU are frequently co-located with NHS hospitals, and make use much of the infrastructure and facilities of the existing hospital (often on a subsidised basis).

⁵³ For example, a private operator may operate private independent sector treatment centres that primarily deliver NHS services. PPU were traditionally facilities that were owned and operated by an NHS trust with the involvement of a private operator. Many PPU now consist of property lease arrangements under which a Trust leases land to a private provider, which builds a new hospital and pays a lease and revenue share.

5.13 There are numerous examples of private operators partnering in PPUs in areas where they did not previously have a facility. For example:

- (a) HCA operates Harley Street at Queen's in Romford in partnership with Baking, Havering and Redbridge University Hospitals NHS Trust. HCA did not have a facility in this area prior to partnering in the PPU. The PPU facility provides cancer care (both medical and surgical), general surgery, neurosurgery, and treatment for haematological disorders. Services include diagnostics, inpatient, outpatient and day care treatments.⁵⁴
- (b) HCA also operates the Christie Clinic private cancer centre in Manchester in partnership with The Christie NHS Foundation Trust. The Christie Clinic is a dedicate cancer centre for private patients.⁵⁵ HCA had no facilities in the area prior to partnering in the PPU.
- (c) Mater Private Healthcare operates the Clatterbridge Clinic on the Wirral in partnership with the Clatterbridge Cancer Centre NHS Foundation Trust. The clinic provides radiotherapy and chemotherapy services for patients with all types of cancers. Mater Private Healthcare had no facilities in the area prior to partnering in the PPU.

5.14 There is a significant variation in the approach taken to PPUs by NHS Trusts. At present, most PPU tenders issued by NHS Trusts relate to the development of a full stand-alone private hospital. However, there have also been examples of NHS Trusts issuing tenders to refurbish and run a ward, or undertake some other smaller project as a partner in a PPU. In practice, where the planned PPU activity is small-scale, the incumbent may be the only private provider that would wish to enter into that partnership.

(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?

5.15 As currently formulated, the proposed remedy is very opaque, simply stating that it would work by “*preventing the owner of a hospital in a Single or Duopoly area from partnering with an NHS trust to operate a PPU.*” A lack of clarity regarding the parameters for determining whether a particular private operator would be prevented from bidding to partner in a PPU (*e.g.*, because it is not clear whether an operator is active in the same geographic area as the proposed PPU or whether an existing private hospital is a Single or Duopoly hospital) could deter private providers from participating in tenders, or from investing in PPUs.

5.16 Some NHS trusts have already sought to require Spire to guarantee that this proposed remedy would not bar Spire from operating the PPU as a condition of

⁵⁴ See <http://www.harleystreetatqueens.co.uk/>

⁵⁵ See <http://www.hcahospitals.co.uk/our-hospitals/find-a-hospital-or-outpatient-centre/the-christie-clinic/>.

participating in the bidding process at all. In other words, awareness in the marketplace of this proposed remedy is already having an adverse effect in deterring operators and trusts from participating in tenders where there is uncertainty about its application.

5.17 This could also distort NHS tender processes by deterring the NHS from considering particular bidders due to the risk that they could be disqualified. Such an outcome could create difficulties for the NHS in identifying effective operators to partner in PPUs and could result in the development of less effective PPUs.

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

5.18 In general, where there is sufficient private demand to support the establishment of a PPU (and a Trust comes up with a commercially sensible proposal), partnering in that PPU should be a profitable opportunity.⁵⁶ Such an opportunity would therefore likely be attractive to a variety of potential partners, private or otherwise.

5.19 If, for whatever reason, no partner could be found, this would be likely to result in customer detriment because a PPU that was less effective or less efficient would be developed.⁵⁷

(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?

5.20 A number of aspects of the proposed remedy may require careful monitoring. For example:

- (a) Whether a private hospital is operating in the same geographic area as the proposed PPU;
- (b) Whether an existing private hospital is a Single or Duopoly hospital; and
- (c) (If permitted by the proposed remedy) whether an NHS Trust should be permitted to partner with an incumbent Single or Duopoly hospital operator in a PPU where no other operator can be identified within a reasonable time period (*e.g.*, with respect to the efforts that a Trust must make to identify another operator, or the circumstances in which a Trust can reject a proposal to partner in a PPU *etc.*)

⁵⁶ The private provision of healthcare services by NHS Trusts does not require a private partner (*e.g.*, a Trust can operate a PPU independently or provide private services within an existing facility). Spire's response to this question focuses only on the circumstance in which a Trust is seeking a private partner.

⁵⁷ In this regard, Spire's understanding of efficient and high quality hospital operation benefits PPUs, reducing the operating costs of the unit to the NHS and maximising the return to the NHS/public purse of the PPU income.

5.21 An effective and more practicable approach to the remedy might be to specify that the acquisition of a PPU contract is a relevant merger situation under the Enterprise Act 2002 (if the thresholds are met) and, therefore, subject to merger review.

5.22 The OFT's ability to review such notifications would be significantly enhanced if a clear framework for assessment – *e.g.*, with respect to catchment areas – were provided (as it is entirely unclear how the OFT could apply a LOCI assessment, or interpret the CC's approach to single and duopoly areas). This approach would also have the benefit that a practice would develop over time that would allow parties some degree of certainty or predictability. The OFT is well placed to assess the competitive effects of a transaction such as the acquisition of a PPU contract, and can likely perform this role more effectively than a stock rule that may be difficult to apply and require ongoing monitoring.

6. REMEDY 4 – PREVENTING HOSPITAL OPERATORS FROM OFFERING TO 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 BARRIERS TO ENTRY THAT IS LIKELY TO BE AT LEAST AS BENEFICIAL TO COMPETITION AS ANY DISTORTION IS HARMFUL.

Overview

- **Spire agrees with the CC that direct incentives in the form of payments for referral should not be permitted.**
- **Spire is concerned, however, that the CC’s provisional conclusions overstate the scope and potential impact of incentive arrangements.**
- **The proposed remedy risks preventing certain arrangements that benefit patients by bringing new facilities, services, and consultants to the market.**
- **Any remedy must be proportionate to the (limited) extent of the concerns raised. A Stark Law-type remedy would be expensive and burdensome to implement, and would be wholly disproportionate. A disclosure-based monitoring scheme overseen by Monitor would be an effective and proportionate way of achieving the CC’s aims.**

(a) 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 lower 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?

6.1 As a hospital provider whose business is based on competing on quality and cost, Spire agrees with the general principle that hospital operators should not be permitted to offer economic incentives to consultants solely for purposes of incentivising them to refer patients to their facilities (irrespective of whether such arrangements raise competition issues).

6.2 Spire also agrees with the CC that:

- (a) The extent of such arrangements is likely to be limited in practice since, as the CC recognises, ethical and regulatory constraints that apply to consultants can be expected to offset “to a substantial extent” any economic incentive for a consultant to offer advice that is not in the patient’s best interest.⁵⁸ Any remedy should therefore be proportionate to the (relatively limited) extent of these concerns.

⁵⁸ Provisional Findings, para. 8.129.

- (b) Certain arrangements between hospitals and consultants can have significant pro-competitive effects. As the CC notes, equity participation is an effective means of incentivising consultants to commit to working at a new hospital, thereby supporting the entry of new facilities. This is particularly likely to be the case with respect to new and innovative service offerings, which neither a PHP nor a consultant would be able to bring to market alone. An example of this is Spire’s high quality Montefiore Hospital, which has brought much needed competition to the Brighton market and has clearly had a positive effect on competition.

6.3 However, Spire believes that:

- (a) The CC’s provisional conclusion in the PFs overstates the scope and potential impact of incentive arrangements with consultants.⁵⁹
- (b) The proposed remedy runs the risk of preventing many arrangements that benefit patients by bringing new facilities, services, and consultants to the market, or encouraging the use of emerging technology that may ultimately result in more cost-effective healthcare.
- (c) Since, as the CC recognizes, consultant incentive arrangements are likely to have the potential to interfere with consultants’ decision-making only in relatively limited circumstances,⁶⁰ any remedial action taken by the CC should be no more onerous than is necessary to prevent the AEC caused by this relatively limited body of arrangements.⁶¹

6.4 In paragraphs 6.10-6.12 below, Spire sets out in detail the arrangements that it believes should be permitted.

Monitoring and oversight

6.5 Within this context and taking account of Spire’s own proposed adjustments to the CC’s draft remedy, a disclosure-based monitoring system (with *ex post* investigation where necessary) would be an effective and proportionate mechanism of enforcement in light of the AEC alleged.

6.6 The key features of such an enforcement mechanism would be as follows:

- (a) The system would be overseen by Monitor, which is a credible independent agency with considerable expertise and experience in overseeing competition in the healthcare sector. The use of an existing body would also help to minimise enforcement costs.

⁵⁹ For example, even though the PFs suggest that it would be very rare for arrangements relating to diagnostic tests or treatment to affect the advice a consultant provides to patients, the CC nevertheless concludes that “*incentive schemes do affect consultant behaviour*” and that “*incentive schemes operated by private hospital operators which encourage patient referrals for treatment at their facilities [...] are a feature of the market that gives rise to an adverse effect on competition.*”

⁶⁰ See, e.g., Provisional Findings, para. 8.129.

⁶¹ See, Competition Commission, Guidelines for market investigations, para. 344.

- (b) Private healthcare providers (and other industry participants, such as equipment suppliers, PMIs, and GPs) would be required to notify Monitor automatically and immediately of any arrangements entered into with consultants. Monitor would maintain and publish a list of all arrangements notified to it on its website.
- (c) Any complaint about consultant arrangements would be submitted for consideration to Monitor, which would investigate the complaint, hear the parties involved, rule on the compatibility of the arrangements with the applicable rules, and also rule on any remedial action necessary.
- (d) Monitor's remit would include *inter alia*: (1) assessing whether the benefits of an incentive scheme in terms of encouraging market entry outweighed any distortive effects; (2) assessing whether the terms of arrangements with consultants were at "fair market prices"; (3) assessing whether any applicable *de minimis* threshold was met.

6.7 Spire considers that the costs of funding such a scheme should not be excessive. Spire suggests that Monitor's costs in enforcing the scheme could be met by the firms that fall under its remit (through either an annual fee or on a per-complaint basis). These costs are likely to be relatively modest in any case (*e.g.*, perhaps limited to the deployment of one additional full-time employee at Monitor, as well as limited legal and administrative costs).

(b) Is the remedy reasonable? Should certain kinds of arrangements 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?

The proposed remedy risks preventing beneficial market entry and therefore needs to be adjusted

6.8 The proposed remedy envisages a broad prohibition that would prevent all consultant incentive schemes subject to relatively limited exceptions. Spire considers that such a "broad-brush" approach will prevent arrangements that bring new services, facilities, and consultants to the market and also risk prohibiting day-to-day arrangements of minimal value and/or provided at market rate. (*See para. 6.9 and following, below.*)

6.9 There are uncertainties in the current drafting that need to be removed:

- (a) As drafted, the remedy would prevent hospital operators from offering any kind of incentives to consultants, except for arrangements in which ownership interests result "*in a reduction in barriers to entry that is likely to be at least as beneficial to competition as any distortion is harmful.*" It is unclear whether this exemption would apply only to "*certain equity partnerships between hospital operators and consultants*" (*i.e.*, equity interests in full-scale hospitals), or include co-investment schemes for specialist clinics (*i.e.*, facilities short of a full-scale hospital) or for particular pieces of equipment.

- (b) Clarity is required around how this provision would operate in practice, and which parameters would govern the assessment of whether the reduction in barriers to entry brought about as the result of a co-investment arrangement would be “*likely to be at least as beneficial to competition as any distortion is harmful.*”

Arrangements with consultants which clearly operate in the interests of patients

6.10 Free or discounted consulting rooms and administrative support to consultants entering private practice for the first time:

- (a) The costs for a new consultant entering private practice can be very significant, with many consultants unable to cover their costs in the first year of practice. The provision of free or discounted consulting rooms and administrative support (such as secretarial support) by PHPs can therefore provide important support for a consultant entering private practice (and in turn benefit patients by bringing new supply into the market).
- (b) Any remedy should allow PHPs to provide relatively low-value non-cash support through free or discounted consulting rooms and administrative support to new consultants in their first twelve months of private practice. Such support should of course not be dependent on the referrals, volumes or revenue that the consultant brings to the PHP.

6.11 The co-development of new facilities or services that fall short of full-scale hospitals:

- (a) The co-investment arrangements that would qualify for the potential exemption appear to be limited to equity interests in full-scale hospitals and would not be available for co-investment schemes for facilities short of a full-scale hospital (*e.g.*, specialist clinics or particular pieces of equipment).
- (b) The proposed remedy does not make clear when a facility will be considered to offer a sufficiently “*wide range of health activities*” to be classified as a full-scale hospital and, therefore, become eligible for the envisaged exemption.⁶²
- (c) The CC is confused on this point.
- (i) On the one hand, it acknowledges that there are pro-competitive effects associated with consultants taking equity shares in new hospitals,⁶³ since it incentivises consultants to working in advance at a new hospital, which may take several years to build and equip; which, in

⁶² This may also conflict with the definition of a “hospital” used for purposes of the market investigation reference, in which a hospital was defined as: “*any facility where either medical (including diagnostic and pathology) or surgical procedures are carried out on an in-patient, day-case and/or out-patient basis.*” There appeared to be no requirement, in this regard, that a hospital must offer a “*wide range*” of health services. See Market Questionnaire, para. K.

⁶³ See, *e.g.*, Provisional Findings, para. 8.123.

turn, strengthens the viability of a business plan and the ability to obtain financing.

- (ii) On the other hand it suggests that the “incentive properties” in narrower schemes (*i.e.*, limited to a particular service or piece of equipment) are “closer to those of a referral fee than those of a more diluted share in the profit from a wide range of health activities, such as a general hospital.”⁶⁴
- (d) Some consultants are keen to promote innovative services and procedures that are entirely new (or at least new to private practice). In many cases, the consultant may seek to partner with a hospital group, which has the financial resources, management and marketing skills to bring the new service to market (but lacks the speciality expertise to launch the service itself). As there is often no proven (or even measurable) demand for novel services, a high degree of financial risk exists around such arrangements. A PHP places significant reliance not only on the consultant’s clinical skills but also on their assessment that there will be private patient demand for the service. In these circumstances, a risk-sharing approach, in which a PHP co-invests with a consultant (who may lose their investment if the venture is misconceived) can help consultants to launch these novel services. Absent such co-investment, new services – which expand patient choice and drive innovation – may not come to market. For example:

✂

New equipment. Some pieces of kit are too expensive and therefore too much risk for a hospital without co-investment from the consultant and without such investment the private market will not be able to keep up with clinically appropriate innovations in new equipment.

- (e) In all cases, permissible co-investment should be limited to the investment of cash or tangible assets by the consultant and the distribution of profit or revenue created by the investment should be proportionate to the consultant’s investment.

6.12 Day-to-day arrangements relating to the provision of treatment to patients:

- (a) There are other arrangements relating to the day-to-day provision of treatment to patients, most of which are either of minimal value and/or are provided at market rate. These types of arrangements have no effect on consultants’ decision-making and/or competition between hospitals and operate to the benefit of patients, and therefore should not be prevented.
- (b) Indeed, the kind of broad prohibition apparently envisaged by the CC could have perverse results. For example, would the fact that consultants help

⁶⁴ Provisional Findings, para. 8.131.

themselves to complimentary coffee or make use of parking facilities at a PHP's facility require to be monitored and declared? A scheme that prohibits such minor and incidental benefits (or requires them to be logged and registered) would seem absurd.

- (c) Examples of the types of arrangements that should not be prevented under the proposed remedy include:
- (i) **Promotional activities.** In its provisional findings, the CC indicates that its assessment of consultant incentives “distinguishes” between “*promotional activities such as seminars or marketing communications*” and “*incentive schemes*,”⁶⁵ which suggests that “*promotional activities*” do not fall within the scope of the prohibition provided for by the proposed remedy. Given that PHPs typically engage in diverse “promotional” activities (*e.g.*, GP engagement, website support *etc.*) for consultants, the remedy should clearly indicate which types of arrangements will not fall within the scope of the proposed remedy.
 - (ii) **“Package” pricing arrangements.** PHPs typically offer self-pay patients “package” prices, including consultant fees, to simplify the purchase of private healthcare for individual consumers since they benefit from the payment of a single bill.⁶⁶
 - (iii) **Paying consultants fair market value for goods and services.** For example, PHPs may engage GPs/consultants to provide clinical advice, PHPs may licence/lease property from consultants/GPs, or pay consultants for use of equipment which they wholly own.
 - (iv) **Training, development and revalidation.** PHPs should not have to charge consultants for professional training/development and GMC revalidation for consultants who have primarily private practices (consultants with NHS positions are revalidated by their Trusts without charge).

Key clarifications required

6.13 It is important that a clear and consistent framework of rules is provided. There remains uncertainty around the definition of several terms and concepts that are central to the operation of the proposed remedy. For example:

- (a) **Definition of “ownership.”** The proposed remedy suggests that the only exemption from the broad prohibition of consultant incentives would be the “ownership” of facilities (where entry is likely to be at least as beneficial to competition as any distortion is harmful). Based on the approach adopted in

⁶⁵ Provisional Findings, para. 8.118.

⁶⁶ There are also specific situations in which PMIs have negotiated an agreement pursuant to which a PHP provides a package price, including consultant fees, for a particular treatment.

the PFs, the definition of “ownership” should capture both equity ownership and other forms of profit-sharing. In any case, this should be clarified if this remedy is implemented.

(b) **Definition of “hospital.”** A “hospital” for the purpose of the market investigation reference has previously been defined as: “*any facility where either medical (including diagnostic and pathology) or surgical procedures are carried out on an in-patient, day-case and/or out-patient basis.*”⁶⁷

(i) As explained above, the proposed remedy does not indicate when a facility will be considered to offer a sufficiently “*wide range of health activities*” to be classified as a full-scale hospital in order to be eligible to fall within the scope of the envisaged exemption.

(ii) In addition, the proposed remedy could be understood to prevent consultants from investing themselves to develop their own wholly-owned healthcare businesses (which is an odd position since there have been significant instances of entry by consultants).⁶⁸

(c) 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 and less expensive hospitals?

6.14 The remedy appears intended to address the concern expressed by the CC that hospital operators might “*choose to compete over rewards to consultants rather than on the basis of the quality or price of their facilities.*”⁶⁹ If arrangements between consultants and hospitals are considered capable of giving rise to such an effect (and such effects are considered to distort competition) the same principle must apply to similar arrangements between consultants and other entities active in the private healthcare industry. It is crucial that the remedy must result in a level playing field to avoid unintended distortion of competition.

6.15 Any remedy should therefore also cover the arrangements between consultants and PMIs, GPs, and firms providing diagnostic services:

(a) **Arrangements between consultants and firms providing diagnostic services** (e.g., laboratories supplying diagnostic tests, firms supplying diagnostic services such as imaging *etc.*). The CC has specifically suggested that “*incentives to conduct unnecessary diagnostic tests or consultations are [...] likely to have more effect on consultants’ behaviour than incentives to over-treat.*”

⁶⁷ Market Questionnaire, para. K.

⁶⁸ For example, a group of gastroenterologists introduced the Vale Hospital in Cardiff (these consultants later entered into a partnership with Nuffield) and a radiologist introduced The Edinburgh Clinic in Edinburgh (this consultant has since entered into a partnership with Aspen).

⁶⁹ Provisional Findings, para. 8.124.

- (b) **Arrangements between consultants and PMIs.** Although schemes by PMIs to reward consultants who recommend cheaper treatments and less expensive hospitals may ensure that consultants advise patients on the basis of price, they may incentivise consultants to place less weight on considerations of the patient’s best interests and, therefore, fall within the ambit of the concerns identified in the PFs.
- (c) **Arrangements between consultants and GPs.** The PFs suggest that incentives might also be used to “*encourage GPs to refer patients to consultants who use their facilities.*”⁷⁰

(d) Are there regulatory regimes in other jurisdictions that the CC could learn from in the context of remedy specification 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?

6.16 A number of observations can be made about the Stark Law:

- (a) The Stark Law is only one of numerous laws in the US addressing financial arrangements with physicians, particularly with respect to physician referrals for Medicare and Medicaid patients.⁷¹ (Medicare and Medicaid are publicly-funded social insurance programs available to certain categories of US citizen. However, the majority of the population in the US have private health insurance, either through their employer or purchased directly.) Physicians are prohibited from referring Medicare patients to designated health services in which they, or an immediate member of their family, have a financial interest (including ownership, investment, or compensation arrangements). Designated medical services include services such as laboratory services, physical therapy, radiology, drugs and prostheses. All financial arrangements between hospitals and physicians (from physician salaries to doughnuts in the break room to parking spaces) must fall within a specific exemption to the Stark Law.
- (b) Far from being a straightforward and readily implementable regime, the Stark Law has become an extremely complex set of rules and exceptions.
- (i) Although the Law itself is fairly short, there are now nearly 1,000 pages of Federal Register guidelines, interpreting notices, rule-making and other materials seeking to explain and interpret the Stark Law. Several years after the law’s introduction, the Centre for Medicare and Medicaid Services (*CMS*) continues to develop a material amount of Stark Law-related guidance and processes on a continual basis.

⁷⁰ Provisional Findings, para. 8.1.

⁷¹ Medicare guarantees access to health insurance for patients aged 65 and older, younger people with disabilities, and persons with end-stage renal disease or Amyotrophic lateral sclerosis. Medicaid is a means-tested health program for families and individuals with low income and resources.

- (ii) In practice, the body of rules relevant to the application of the Stark Law is ambiguous, complicated, and cumbersome. Complying with these rules is time-consuming and the costs attached can be significant.
 - (iii) Indeed, Former Congressman Pete Stark, the law's original sponsor, has stated in recent years that the law has become too complex, and too far removed from its original intent, and has called for it to be repealed.⁷²
- (c) The Stark Law has been widely criticised for its overly blunt approach to physician-hospital relationships. It was implemented essentially as an anti-fraud measure, but has been criticised as its use has been expanded to cover conflicts of interest and related questions. This helps explain why not all states have adopted similar legislation (many States have anti-bribery statutes that capture inappropriate arrangements under which physicians are compensated for patient referrals).
- (d) It is not therefore considered appropriate to introduce a Stark Law approach to the UK market.

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

Monitoring Costs

6.17 The cost of a disclosure-based monitoring regime, overseen by Monitor, would likely be relatively modest (amounting to little more than some additional staffing costs for Monitor). By contrast, as explained above, the costs imposed by a Stark Law-type regime would likely be significant (and wholly disproportionate to the concerns identified).

Treatment of existing arrangements

6.18 The immediate termination of existing arrangements between hospitals and consultants could lead to the termination of certain services, resulting in disruption for patients. This should be reflected in the transitional measures that would apply to existing arrangements.

6.19 For example, where Spire has jointly invested in a piece of equipment with a consultant, it is not clear that it would be financially viable for either party to purchase the other's ownership interest. If these arrangements were to be somehow prohibited, this could put continuity of service to patients at risk and lead to existing services leaving the market completely.

72 See, e.g., Modern Healthcare, 2 August 2013, *Pete Stark: Repeal the Stark law*, available at: <http://www.modernhealthcare.com/article/20130802/blog/308029995/>.

- (a) If Spire were to purchase the consultant's stake in the equipment, Spire would carry the risk of the consultant moving to a different facility without the hospital identifying a replacement consultant to carry on the service.
- (b) If the consultant were to purchase Spire's stake in the equipment, the consultant may not be able to procure facilities to operate the equipment independently.
- (c) Accordingly, any existing arrangements under which consultants invested cash, or contributed tangible assets, should be "grandfathered."

6.20 While it would be more feasible to wind down purely contractual arrangements (in which consultants have not invested cash or contributed tangible assets), there remains a material risk of service disruption. Existing contractual arrangements should therefore be allowed to continue until the end of the current contract term. Where there is no fixed expiry date in the contract, notice should be provided in accordance with the terms of that contract. At the very least, there should be an extended period of at least six months for an orderly wind down of existing arrangements.

(f) 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?

6.21 See the answers given above.

7. REMEDY 5 – A RECOMMENDATION TO THE HEALTH DEPARTMENTS OF THE NATIONS 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.

(a) Is the proposed remedy practicable in all of the nations? Where a consultant practices 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?

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

(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? 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?

(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?

(e) With what frequency should performance indicators be updated?

7.1 Spire is not commenting separately on this proposed remedy, as Spire adopts the submissions of PHIN for this purpose.

8. REMEDY 6 – REQUIRE ALL CONSULTANTS PRACTISING IN THE PRIVATE HEALTHCARE SECTOR TO PUBLISH THEIR INITIAL CONSULTATION FEES ON THEIR WEBSITES AND REQUIRE EACH PRIVATE HOSPITAL WHERE THEY HAVE PRACTISING RIGHTS TO PUBLISH THESE FEES ON THEIR WEBSITES. REQUIRE CONSULTANTS TO PROVIDE A LIST OF PROPOSED CHARGES TO PATIENTS IN WRITING, IN ADVANCE OF ANY TREATMENT.

(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?

(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? As there particular medical specialties where consultants would face particular problems in providing such an estimate in advance? How else might patients be informed of the likely costs of their treatment?

(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?

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

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

8.1 Spire is not commenting separately on this proposed remedy, as Spire adopts the submissions of PHIN for this purpose.

9. REMEDY 7 – REQUIRE 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.

(a) Is the 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?

(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?

(c) Besides HES and PROMs equivalent data, what other data should be collected by private hospitals and to whom should it be made available? Would it be appropriate for the CC to specify the coding, for example, ICD10, to be used in data collection and classification?

(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?

(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?

9.1 Spire is not commenting separately on this proposed remedy, as Spire adopts the submissions of PHIN for this purpose.

10. REMEDY 8 – A PRICE CONTROL SETTING THE MAXIMUM PRICES THAT COULD BE CHARGED AT HOSPITALS WHICH THE CC CONSIDERS HAVE MARKET POWER

Overview

- **The CC has not established any AEC to the requisite standard and therefore there is no need for any remedy.**
- **Spire agrees with the conclusions of the CC this could not be an appropriate remedy in any case.**
- **A price control remedy would be impossible to design, specify, implement, and monitor within the context of the private healthcare market.**
- **A price control remedy would be likely to lead to adverse unintended consequences.**

10.1 Although the CC considered this remedy would be effective for both insured and self-pay prices, it is not pursuing it because:

- (a) It would not address the root cause of the problem – the CC has a clear preference for remedies which address the cause of a competition problem and not its symptoms.
- (b) It would be complex to design and update, and would require the provision of some form of adjudication in the event of disputes and would be likely to have unintended consequences, such as deterring new entry.

10.2 Despite these drawbacks, the CC did consider whether a price control would be an appropriate remedy in the case of Single and Duopoly areas where, despite the rise in local pricing that might arise from remedies 2 or 3, new entry or expansion was unlikely. On balance, the CC decided that it would not be an appropriate remedy.

10.3 Spire respectfully agrees. First, the CC has failed to establish that Spire has market power at a national or local level. Second, in any event, in the circumstances of this particular market, a price control remedy would be impossible to design, specify, implement and monitor.

- (a) There are literally thousands of Spire individual prices that a price control remedy would need to address. New treatments and changes in the nature of treatments would require frequent revisions to be made. (The same, of course, is also true for other hospital groups.) There is no sensible basis on which such a scheme could be devised.
- (b) Specification of the test for the “controlled price” would be extremely difficult to work out: this is particularly the case in the context of a high fixed-cost business where the allocated costs per procedure are difficult to work out. Where the CC has considered price control remedies in other cases, those

remedies have concerned products or markets with a much lower degree of differentiation.

- (c) Monitoring would be a data-intensive and would be made more difficult where *ad hoc* discounting – whether client-specific or hospital-specific – was involved.
- (d) Monitoring would also be hampered in the event that there were changes in the way that a treatment was delivered (*e.g.*, a change in the underlying quality and service associated with the treatment whose price was regulated). This feature could have the unintended consequence of limiting innovation (*e.g.*, because offering better quality and service may not be worthwhile if the price for the treatment was capped).