

OFT'S COMMENTS ON THE CC'S NOTICE OF POSSIBLE REMEDIES IN THE PRIVATE HEALTHCARE MARKET INVESTIGATION

General remarks

Introduction

1. We agree with the thrust of the CC's proposals. What follows comprises detailed suggestions and questions for the CC to consider in designing suitable remedies - and comments on the practicalities of monitoring and enforcing some of the remedies.

Detriment levels

2. We note that the level of detriment found by the CC in this market is high both in absolute terms and in terms of its percentage value of the market (a conservative estimate of £173m – £193m per annum, equating to 10 – 11% of the revenue of the three largest private hospital operators: and this does not include detriment arising from consultants' activities). This, coupled with the CC provisional findings of weak competitive constraints in the provision of privately funded healthcare in local markets, suggest that a comprehensive remedies package is called for.

Ensuring free flow of clear information to consumers

3. Remedies ought to be designed to ensure that the consumer is engaged as early as possible in deciding on location of treatment and who will carry it out and pay for it (and how much). For example, consumers will need to know what their insurers will pay for and what they will be liable for themselves. If this information is provided after they have initially selected the consultants (without access to full information), they may well be reluctant to switch away to a new one.

Hospital locations

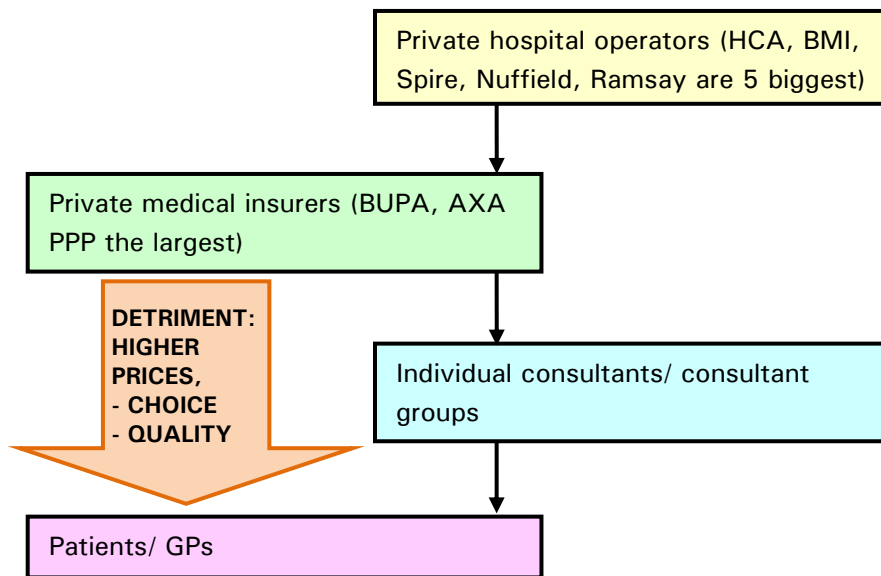
4. The CMA will need to be clear about the location of all private hospitals and PPUs. We might be able to seek help with this from the GIS via the Public Sector Mapping Agreement.

Consultants

5. The CC will need to ensure that remedies put in place do not act to discourage consultants from working in certain areas or even in the UK at all. This said we do not see any obvious risks of this arising from the remedies which have been suggested.

Mapping market power and detriment

6. Market power and detriment seem to be present as in the diagram below.



Entry costs

7. We think that the remedies which are aimed at either changing the structural make up of local markets by divestment (and thereby encouraging new entry) or at controlling the ability of incumbent hospital operators to earn monopoly rents have to be viewed in light of the fact that, based on what the CC has said about the costs of new entry, green field entry to any local market on a major scale may be rare or unlikely.
8. What scope is there for significant lower cost new entry to a local market by means of establishing private patients' units (PPUs) in NHS hospitals? We wonder whether hospital operators might try to reduce the CC's concerns by claiming that this is possible and has been done successfully,

assuming there are any instances where entry has been made by other than one of the incumbent private hospitals in a local area.

Defining geographic markets

9. Geographical markets might vary in size according to the type of treatments customers wish or need to have: the extent of this variance is likely to depend on the extent to which private hospitals specialise in certain sorts of treatment.
10. In order to avoid complex arguments about the extent of geographical markets and whether or not there are chains of substitution between them, it might be desirable to devise a bright line test for the extent of geographical areas which are to comprise geographical 'markets' for the purpose of the remedies. This might not be an easy exercise as remedies could be open to challenge in areas devised where there was perceived to be competition from contiguous areas and/or there was evidence of a strong chain of substitution. However, a test could be devised along similar lines to that in Schedule 4 to the [Groceries Market Investigation \(Controlled Land\) Order 2010](#), the principle of which was not opposed by the large grocery retailers, as far as we are aware.

Remedy 1 – Divestment

11. We agree that there would be no point in requiring divestment in 'Single' or 'Duopoly' areas and that the divestment option ought only to be considered in areas where there are clusters of commonly operated hospitals.
12. In relation to divestment, the CC would need to ensure that this did not reduce choice for patients through the purchaser offering a narrower choice of treatments. Furthermore, provision would need to be made to ensure that patients' courses of treatment were not disrupted or curtailed because of the change of ownership of a hospital; and also that service levels were not reduced - e.g. through waiting times for treatment being increased or treatment no longer being offered.
13. The annex to the Notice on divestment options refers to LOCI analysis being used to identify clusters of hospitals. This seems critical to identifying hospitals which might require divestment. Accordingly the term

and the analysis done needs to be explained, not least because the hospital operators are likely to put up a strong resistance to a divestment remedy.

14. The CC found that the level of consumer detriment in the overall market equated to 10 to 11% of the leading hospital operators' turnover from private healthcare. The price cost analysis work carried out by the CC suggested that reductions of around 20 percentage points in a hospital's weighted average market share would be expected to lead to a decline in prices for self pay patients of 2 – 6%. This suggests that divestment could make a substantial contribution in removing the overall detriment in the market (up to around half) and is therefore well worth considering as a remedy.
15. The CC may need to bear in mind that there could be circumstances in which divestment could lead to a change in the geographical definition of a local market – for example if the acquirer of a hospital or group of hospitals had different specialisms and/ or had links to consultants and PMIs with a wider or narrower geographical area of operation which were enough to change the overall market definition.

Remedies 2a and 2b – general points

16. We agree with the potential risk of circumvention. The remedy would need to be devised to ensure, as far as possible, that PMIs would pass on any benefits gained from the reduction in hospitals' market power to their policy holders.
17. We also wondered if there is a danger that either of these remedies would transfer too much market power to PMIs given that this sector is concentrated too?
18. Is it known to what extent large employers or other large organisations influence individuals' choice of private medical insurer?
19. Is it known how long contracts usually are between PMIs and hospitals? Would requiring contracts to be shorter (especially where they are not on a hospital by hospital basis) help the process of competition by affording PMIs more opportunity to negotiate improved terms?

Remedy 2a – preventing hospitals from taking punitive price measures against PMIs in certain circumstances

20. It appears to us that it may also be necessary to define what a PMI's change in network policy would be which would be likely to cause patient volumes to fall and might cause an adverse reaction from hospital operators, for example:
- a. Change in the PMI's list of approved hospitals (could be either or both a reduction in the number of approved hospitals or an increase in approvals of a rival's hospitals)
 - b. Change in the PMI's list of approved acute treatments for any or all of the PMI's list of approved hospitals
 - c. New or changed restrictions on what consultants can offer what treatments at what hospitals
 - d. Offers or incentives to consultants to work from particular hospitals
 - e. Changes in criteria for admission of hospitals and /or treatments and/or consultants to a PMI's approved list
21. The definition would have to be comprehensive and future proof in order to prevent circumvention of the remedy by hospital operators.
22. How would it be proved that a change in a hospital's prices were linked to a change of policy of a PMI rather than other factors? Hospitals would and should of course be free to adjust their prices as they see fit, especially in response to competition.
23. Change in prices would have to be quite tightly defined in any remedy, and be as future proof as possible. For example it is possible that a hospital operator might not make any adjustment to what it sees as its main prices to PMIs at the time the PMI changes its policy but might delay such price changes or make them elsewhere where and when it thinks such price changes might be less visible. In other words the remedy would need to cope with time-shifting price changes and deal with price changes in areas

not necessarily related to the mainstream price changes made to PMIs. Or changes could be made in kind, such as restrictions on the choice by PMIs of the consultants they want to use. Alternatively, price changes might be made to the PMI in a different local area.

24. There could be a waterbed effect if prices charged to PMIs were controlled insofar as hospital operators might seek to recoup the loss of profits from self-paying consumers, especially where these form a significant proportion of their business.
25. We are concerned that this remedy would require a high degree of monitoring for it to stand a chance of working, especially given the difficulty or impossibility of devising some bright line definitions – such as when can a price rise related to a change in a PMI’s policy be counted as such? Nevertheless we believe it is a remedy worth investigating further. One way round the difficulty of proof of transgression might be to have some kind of arbitration mechanism in place, as is facilitated by the remedies put in place in the local bus services market (access to bus stations) and the groceries market (delisting of suppliers – overseen/regulated by the Groceries Supermarkets Code of Practice and the Groceries Code Adjudicator).

Remedy 2b – separate pricing of hospitals

26. At first sight this would remove the ability of hospitals to take punitive measures against PMIs who changed their hospitals or treatment list/consultant policies. However, there would be likely to be extra cost in negotiating the separate prices for each hospital. It is not clear exactly what the difference in cost and resources would be to negotiate prices per hospital. It would be useful if a worked example could be given.
27. The remedy might be easier to monitor and enforce if existing contracts came to an end on a particular date rather than provide for them to run their natural course. This would then provide a clearer signal to the market of the regulatory change and, more importantly, would remove the ability of hospital providers to extend existing contracts, say by using inventive means of circumventing any regulation aimed at preventing them from doing this.

28. Single hospital pricing might provide PMIs with more negotiating strength by giving them the ability to compare prices and offers from other hospitals run by the same or rival operators.

Remedy 3 – restrictions on expansion

29. The CC will need to be clear that, and preferably have the evidence that, a PPU could constrain the pricing of a competing private hospital. It might be able to do so only to a limited extent in relation to the treatments that a PPU offers but these might well be a narrower range than that offered by a 'rival' private hospital in specific local area.
30. Is there any evidence that a private hospital operator could more easily enter a local market in the form of a PPU as opposed to greenfield entry?
31. The CC has noted concerns about customer detriment if NHS Trusts are prevented from securing the best financial deal in partnering in a PPU and also if this proposed remedy prevented the creation of a PPU in the first place. We think these are concerns which weigh against the justification for this remedy.
32. If the potential competitive effect of a PPU is limited then there might be little or nothing to be gained by this remedy, especially if there is little or no prospect of a PPU operator growing such a business into a fully fledged new private hospital (which in any event would require the PPU operator to find and invest in new premises).

Remedy 4 – preventing incentive schemes being offered to consultants by private hospital operators

33. How does equity ownership by consultants of private health facilities work? Do they own outright some of the equipment and facilities at a hospital or do they have the right to use those facilities for certain periods of time?
34. We agree that Incentive schemes to attract consultants to hospitals may also benefit competition in certain circumstances. A remedy would need not to deter consultants from practising in particular hospitals to the

detriment of consumers. It seems important also that a consultant is satisfied with the facilities offered by a hospital (as it is for patients and PMIs). If this element of competition to attract consultants is removed then costs for consultants might rise and these could be passed on to patients and PMIs.

35. The above said there might be certain kinds of incentive that harm competition.
36. It might be hard to monitor whether private hospital operators were complying with a remedy of this kind because of the number of agreements between consultants, consultants groups and private hospital operators. In addition, consultants who are party to an (enforced) breach of it would not have the incentive to complain if they were benefitting financially.
37. Preventing hospital operators offering consultants any incentives may reduce the availability of treatments to UK patients. Some consultants may decide the exit the local areas concerned or the UK market altogether.
38. The remedy could be monitored by means of compliance reporting, reports being audited by an independent body as is the case in the PPI remedies. However, this could be quite onerous for the parties and the CMA, not least because the number of persons requiring to provide reports could be quite large.

Remedy 5 – Recommendation to health departments on consultant performance indicators

39. In principle this remedy seems to be a good idea. We believe it should be for the relevant health departments to comment on the usefulness of this remedy to consumers and PMIs, and on the ease or otherwise of putting it in place in Scotland, Wales and Northern Ireland.
40. The remedy could be monitored by periodic checking of the relevant web sites to ensure quality and availability of the required information. If this remedy is taken forward we would want to consider further how practicable and effective it would be.

Remedy 6 – Information on consultants' fees

41. In February 1994, DTI published the MMC's report on the supply of private medical services. Paragraph 11.164 of that report said:

We believe consultants should make their charges known to their patients at the earliest sensible opportunity; they should make their charges transparent by showing the elements that make up what would otherwise appear only as aggregate charges; and they should make their charges known to relevant GPs. But arrangements for disseminating information on consultants' charges and for promoting transparency are likely to be successful only if they have the full backing of consultants and GPs. We urge all the bodies representing the interests concerned to co-operate in promoting transparency in consultants' charges, perhaps by agreeing on the terms of a code of practice.

42. There was no formal remedy in this area but the recommendations are in line with what the CC is now proposing.
43. If it is suggested that the BMA has links from its website to consultants' sites where fees might be quoted, you should be aware that as a result of the MMC report, the British Medical Association (BMA) gave statutory undertakings on 24 September 1994 not to publish guidelines on consultants' fees for private medical services.
44. Theoretically the BMA could itself list individual consultants' fees but it could be argued that this would be a little too close to comfort to a guidance document of the kind which the 1994 undertakings prohibit, and would involve consultants providing information on their fees to the BMA, which might encourage collusion and introduce inaccuracies and delay in the reporting of fees information to consumers.
45. We agree that, as well as on web sites, consultants could be required to tell consumers about their fees (along the lines described in paragraph 11.164 of the MMC's report). We suggest that this is required to be at the point of first contact with the patient and immediately before the start and after the conclusion of the treatment. A breakdown of fees would be important, including whether there one price for the course of treatment/operation contemplated (wherein all fees are bundled into one).

46. The website publication requirement of this proposed remedy could be monitored by means of spot checks but this could be difficult given the large number of consultants. It would be harder to monitor the provision of information by consultants to individual patients. Here one option may be to rely largely on complaints from patients coupled with steps to ensure that patients were aware of their rights. One possibility here might be to require the posting in consultants' rooms and on PMIs' and hospital's web sites a summary of consumer rights in this area (a similar requirement was made in relation to the supply of veterinary medicines and seems to work). If this remedy is taken forward we would want to consider further how practicable and effective it would be.
47. We see no reason to exclude consultants earning below a certain level from the remedy. To do this would make it hard to monitor who the remedy covers.
48. Paragraph 71 of the CC's notice of possible remedies notes that some consultant bodies produce a code of practice on charging fee notification to patients. These may point the way towards a suitable remedy in this area.

Remedy 7 – Transparency on private hospital performance

49. We consider it essential for consumers to be able to compare private hospitals with one another and with their NHS equivalents and that facilitating such comparison might aid competition to some degree.
50. For the remedy to work we would need to ensure that consumers knew about it either beforehand or at the point of seeking medical treatment. Expansion in scope of the existing PHIN web site could be considered (www.phin.org.uk) as a remedy. The CC could require all private hospital operators to enter their data on it.
51. Consultants and private hospitals might be required to tell patients about the web site in any communications about their proposed treatment. The BMA might be invited to consider putting a link on their web site to PHIN if one is not already there. There could also be a link on the web sites where the HES NHS data appear to the equivalent data for private hospitals.

52. We have significant reservations as to setting up a separate comparison web site. Web sites can be costly and time consuming to set up and may require constant vigilance to ensure the accuracy and suitability of information on them. There would also be the issue of who should pay for it.

Remedy 8 – Price control

53. We agree that this is an unattractive option. Inevitably, capping prices might deter new entry and would be very difficult to monitor and enforce, especially in relation to innovative pricing strategies not contemplated at the time of the devising of the remedy.

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