

PRIVATE HEALTHCARE MARKET INVESTIGATION

AXA PPP healthcare Limited's response to the Competition Commission's Provisional Decision on Remedies ("PDR") notified 16 January 2014

Introduction

1. AXA PPP healthcare Limited ("AXA PPP") welcomes the publication of the Competition Commission's ("CC") provisional decision on remedies. AXA PPP believes that the package of remedies as defined will serve to increase competition to the benefit of consumers.
2. AXA PPP notes that the CC has not yet made a final decision on the existence and form of any AEC, that the provisional decision on remedies is based on the AECs as set out in the provisional findings, and that the CC's final decision on any AECs and appropriate remedies will take into account all evidence received and submissions made, including responses to provisional findings and provisional decision on remedies.¹
3. In this document AXA PPP provides further comment on anaesthetists where AXA PPP continues to believe there is a strong case for an AEC and responds to the five elements of the package of proposed remedies:
 - Divestiture of nine private hospitals
 - Review by the OFT/CMA of PPU arrangements under which private hospital providers agree to operate PPUs
 - Prohibition of or restrictions on certain clinician incentive schemes
 - Requiring collection and publication of information on the performance of private hospitals and consultants
 - Requiring private hospitals to oblige consultants, as part of their practising privileges, to provide fee information to patients.

In summary AXA PPP highlights a number of areas where it believes greater clarification and definition are required to make the remedies effective, without changing their essential nature.

Anaesthetists

4. AXA PPP has already made a number of representations to the CC in relation to anaesthetist groups. AXA PPP believes that established groups with enduring near-monopolies in certain local areas and which set common prices must, self-evidently, "prevent, restrict or distort" competition on price and constitute an adverse effect on competition. In these areas we believe there are considerable barriers to the entry to or expansion of the local market from new, independent anaesthetists not belonging to any group. AXA PPP refers to its letters of 17 October 2013 and 12 December 2013 and previous submissions to the CC in response to the Issues Statement, AIS, Market Questionnaire and Provisional findings and possible remedies which provide substantive evidence. AXA PPP believes that the strength of its evidence in the light of the CC's preliminary finding in the AIS of a price effect merits a considered response from the CC on whether its final decision on the AECs in this market includes a further finding of an AEC in relation to anaesthetist groups.

¹ CC's Summary of provisional decision on remedies

5. Since the CC has said that its final decision on any AECs and appropriate remedies will take into account all evidence received and submissions made, and the CC has not permitted AXA PPP to see the underlying data, AXA PPP looks forward to the CC's responses on this subject in its final report. Should the CC decide that there is no AEC to be remedied, then, as AXA PPP has already submitted, this is very likely to be interpreted as 'carte blanche' for increasing price alignment by groups of anaesthetists (and by other consultant groups), which AXA PPP asserts is anti-competitive.
6. To prevent this from occurring, AXA PPP believes that the CC should make it clear that although the CC considers the evidence was not sufficiently persuasive to justify an AEC, collective price action leading to consumer detriment would be a matter for concern. Should persuasive evidence of this be forthcoming in the future then remedial action would be necessary to protect consumers.

Divestiture of nine private hospitals

7. As stated in its previous responses to the CC, AXA PPP agrees with the CC's findings that Central London is a unique and specific market in terms of geography, market conditions and the dominance of HCA in primary, secondary and tertiary care markets. AXA PPP has continually had a clear position that to remedy the AEC in London, HCA must be required to divest a proportion of its current portfolio of provision.
8. In Central London HCA owns six of the most prestigious private hospitals, currently runs a very large private patient unit, ("PPU") University College London Hospital ("UCLH"), has a contract to run another PPU (Guy's and St Thomas' ("G&T")) and has interests in a number of other facilities vertically integrated to its main hospitals. As a result HCA receives a significant proportion of admissions and outpatient referrals in Central London and is dominant in the market.
9. HCA negotiates prices across its portfolio of hospitals. HCA has no motivation to introduce price competition between its own facilities and it is not possible for AXA PPP to drive any competition between facilities owned or managed by HCA. Equally, to have a hospital network in London that does not include any of the hospitals owned by HCA is simply not credible or attractive, in particular to corporate customers. The only option therefore is to include all HCA hospitals (because they are negotiated as a package) which is very expensive.
10. In AXA PPP's response to the CC's provisional findings it considered how competition would be effective in the London market. AXA PPP argued that it (and other insurers) would require a minimum of 3 options in terms of establishing networks of providers that could each operate on a stand-alone basis. Therefore each network would require sufficient provision across a broad range of specialisms to enable it to provide treatment to populations of insured patient. To be credible to customers each network would need to have the following minimum requirements:
 - A significant flagship hospital in Central London with an International reputation
 - Harley Street provision
 - Coverage for a full range of treatments to meet the total treatment needs of a PMI population
 - High acuity cover
 - A full cancer service including radiotherapy.

11. AXA PPP strongly believes that having a minimum of three options to offer customers would enable it to negotiate attractive terms with one or more of the groups and then develop a range of products that exclude one or more of the other groups. This would have the benefit of being able to offer customers, in particular in the corporate market, access to a full range of treatments for their employees, locally, at a cost effective price. London has been a particular source of cost inflation on PMI policies and therefore customers requiring London cover have seen high increases in premiums. AXA PPP believes that being able to offer a cost-effective proposition where customers have access to one of the three groups only - that still delivers the full range of treatments and is spearheaded by a flagship hospital - would help to prevent a probable strong decline in members covered in London driven out of the market by exponentially high prices.
12. AXA PPP would envisage developing a broad product range giving customers choices of having one, two or three of the networks of provision included in their benefit package depending on the needs of those customers. AXA PPP believes that the CC's proposed divestiture decisions will open up exciting opportunities in the London market for consumers.
13. In terms of 'flagship' provision, there are 3 highly prestigious, very large hospitals in London:
 - London Bridge
 - London Clinic
 - Wellington.
14. AXA PPP has stated in previous submissions that it believes each of these hospitals should be under separate ownership, enabling AXA PPP to drive competition between these facilities and enable AXA PPP and other insurers to develop propositions that include one, two or three of these facilities in conjunction with other London provision. Therefore separate ownership of these three facilities is critical to enabling achievement of this competition.
15. AXA PPP concluded that HCA should be required to divest a minimum of two hospitals, one out of the London Bridge or the Wellington and one out of the Princess Grace and the Harley Street Clinic. The latter divestment will give the new owner a significant presence in the Harley Street area.
16. Consequently AXA PPP concurs with the conclusions reached by the CC in terms of hospital divestments by HCA. AXA PPP believes that divestiture to a suitable alternative provider is the only effective solution, thus concurring with the CC.

Suitable alternative providers

17. Given the comments above about the three flagship hospitals in London being under separate ownership, AXA PPP strongly argues that X must not be allowed to acquire the London Bridge Hospital – or indeed the Princess Grace Hospital given its presence in Harley Street currently. AXA PPP would expect to have the opportunity to comment on prospective purchasers once they become known.

Remedies in respect of HCA do not go far enough

18. AXA PPP strongly believes that the CC's provisional decision on remedies in respect of HCA divestitures does not go far enough and views the proposed remedy for HCA to divest two hospitals as the absolute minimum divestiture required to remedy the AEC. This is discussed further below.

Primary care facilities should be included in the HCA divestment package

19. AXA PPP has previously noted that HCA's control of primary care facilities gives HCA an opportunity to control referral patterns in London. Vertical integration will likely have very similar effects to incentives. AXA PPP is therefore puzzled that the CC is so rightly concerned with incentives, yet remains so sanguine about vertical integration, especially when such vertical integration is not being disclosed to the consumer. The CC has stated that it has found no evidence that HCA's ownership of primary care facilities has had any effect on referral patterns because there is no evidence that referral patterns from Blossoms Inn and Roodlane changed between HCA acquiring Roodlane and an interest in Blossoms Inn and the period prior to ownership. AXA PPP contends that there is a probability that before HCA invested in these primary care and diagnostic facilities there were referral pathways already in place, probably with incentives attached that encouraged referrals from both Roodlane and Blossoms Inn into HCA hospitals. Therefore it is unsurprising that there is no material change in referral patterns post investment.
20. Blossoms Inn and Roodlane between them provide services to a significant number of corporate customers across London and therefore the clinician at these facilities controls large numbers of people accessing secondary care. The clinicians at Roodlane are employees of HCA and will ergo be required to implement HCA's strategies and follow HCA's care pathways. In AXA PPP's opinion this contractual employment relationship has the same effect as incentive schemes and is likely to influence where clinicians at Roodlane and, perhaps to a lesser but still significant extent, at Blossoms Inn, refer their patients. Without separate ownership AXA PPP is not convinced that a free market will operate and clinicians will at least partially be influenced to make referral decisions based on their employers' instructions.
21. AXA PPP also has a concern that HCA, post divestment, if allowed to retain its ownership of primary care provision, has the opportunity to frustrate an acquirer of the London Bridge Hospital. HCA has the opportunity to set up referral pathways requiring Roodlane and Blossoms Inns to refer patients to retained HCA facilities. Whilst the remedy to prevent incentives goes some way to addressing this, peer pressure from consultants affiliated to HCA will encourage them to continue to make referrals to HCA facilities.
22. AXA PPP urges the CC to consider these factors when making final determinations and to reconsider its decision to allow HCA to continue to own (in full or part) both facilities. AXA PPP considers that HCA should be required to divest either Roodlane or its interest in Blossoms Inn in addition to divesting the London Bridge and Princess Grace.
23. If HCA is not required to divest primary care provision, AXA PPP argues that the following requirements should be implemented:
 - Roodlane and Blossoms Inn should be required to publish their referral patterns on an annual basis showing the percentage number of patients referred to each facility they have used; and
 - Both facilities, in particular Roodlane, are clear in all branding and marketing and wherever their logo appears, that they are owned or affiliated with HCA so that customers understand that they are not independent organisations and may be influenced in their referral decisions.

HCA will retain a dominant share of oncology services

24. On a similar theme, HCA based on the CC's provisional decision, will remain dominant in the Central London market for oncology services. Both the Wellington Hospital and the Harley

Street Clinic have extensive cancer service provision and in addition HCA controls oncology referrals through its ownership of Leaders in Oncology Care ("LOC"). These services are a very significant source of high margin income for any private hospital able to provide them. LOC is according to HCA's own website a leading group of world class consultants and specialists covering all aspects of oncology. LOC provides and manages care for a significant proportion of oncology referrals in London – almost $\frac{1}{3}$ of treatments measured by spend according to 2012 AXA PPP data.

25. In addition to its current position of dominance of cancer provision, HCA has extensive plans to develop this further with significant new provision through its partnership and involvement in developing a new PPU with G&T. This is further discussed below as a separate point. Currently the contract awarded to HCA with G&T enables HCA to develop a facility to provide cancer services which if fulfilled will significantly add to HCA's dominance in this part of the market.
26. AXA PPP continues in its strongly held view that LOC should be run independently of HCA and without the consultants who use it having a financial interest. AXA PPP believes that the CC needs to consider the effect of this on competition for oncology services in their final determination.

Guy's and St Thomas' PPU should also be considered for divestment by HCA

27. AXA PPP believes that the Office of Fair Trading's ("OFT") decision to allow HCA to run the G&T PPU should be revisited by the CMA. As stated above, HCA's current contract with G&T is to develop an extensive cancer facility for private patients within the Trust. This facility would complement the London Bridge Hospital which does not provide a full range of cancer services and enable HCA to draw patients from the South East and other facilities in this area including the Marsden and Parkside.
28. If HCA is required to divest the London Bridge Hospital but retains the right to develop facilities for private patients at G&T it would have the potential to replicate the services it currently provides at London Bridge by developing a broader range of services than cancer. Please also see below in the section on the Shard. HCA's planning application for the Shard indicates that it is intending to run the London Bridge, G&T and the Shard in an integrated and inseparable way. HCA appears to be envisaging that the Shard will become an outpatient and diagnostic centre that will refer patients to both the London Bridge Hospital and G&T PPU. The letter accompanying the planning application refers to HCA plans to move surgical cancer services from the London Bridge to G&T and also lists some other specialisms that it intends to move $\frac{1}{3}$.
29. AXA PPP is concerned that there are two possible outcomes if HCA is allowed to retain G&T post the divestment of London Bridge. These are:
 - HCA continues with its currently described plans to develop a large cancer facility at G&T. The CC is aware that HCA already has a very large share of cancer services in London, a dominant position that is not affected by the divestiture remedy. AXA PPP believes that this outcome would limit the beneficial impact of the CC's proposed remedies.
 - HCA amends its plans post divestment of London Bridge, seeking to use its facilities at G&T when developed to frustrate the ability of the new owner of the London Bridge to make a success of the London Bridge as a going concern. HCA would potentially have the ability to develop viable and equivalent facilities to the London Bridge and then use the Shard as an outpatient and diagnostic centre referring patients only to G&T.

30. For these reasons AXA PPP urges that the decision to allow HCA to develop services at G&T is reconsidered. AXA PPP argues that HCA should be required to surrender the management contract at G&T and suggests that immediately the London Bridge is divested, the management contract at G&T is re-tendered. This process should then become subject to the remedy for PPU ownership.

HCA's plans for the Shard need to be considered as part of the London Bridge divestment

31. HCA has applied for planning permission in the Shard for extensive outpatient and diagnostic facilities. AXA PPP has outlined its concerns about this application in separate submissions to the CC on 12 December 2013 and 27 January 2014. It is clear from HCA's planning application and its statements in the press that HCA is expanding its facilities at the London Bridge Hospital into the Shard. HCA's stated objective is to move outpatient provision from the London Bridge Hospital to the Shard and expand secondary and tertiary care provision at the London Bridge. This expansion needs to be considered as part of the divestment requirements by HCA for London Bridge. HCA's strategy appears to be to use the Shard to expand the footprint of the London Bridge, with the probable intention that the space at the Shard (if granted planning permission) would form part of the London Bridge Hospital.
32. If HCA is granted planning permission for the Shard, retains the facility and carries out its plan to develop an extensive outpatient and diagnostic centre there notwithstanding what happens to G&T, it has the opportunity at least in part to frustrate the CC's remedy of the divestment of London Bridge by altering referral patterns from the London Bridge to its other facilities in London. As detailed above, this ability is further strengthened in the event that HCA retains its facilities at G&T.
33. Therefore AXA PPP believes the Shard should be regarded as part of the London Bridge and should form part of the divestment requirement.

Further Determination for HCA

34. AXA PPP believes that HCA should be required to abide by a non-compete clause with the acquirer(s) of the divested facilities, the exact details of which would need to be defined.

Divestments outside Central London

35. The conclusions reached by the CC about divestments outside Central London concur with AXA PPP's comments made in AXA PPP's response to the CC's Divestment Paper and therefore AXA PPP agrees with the CC's provisional decision and seeks to make no further comments at this stage.

Insurers required to honour existing contract terms for 18 months

36. AXA PPP understands this requirement in principle. HCA and BMI will not be helped in a sale of their facilities if any insurer has the ability to remove or significantly re-negotiate a contract in a short space of time. However, if it is the intention of the CC that insurers retain terms including prices for 18 months except by mutual consent, this will delay for a significant period of time the effectiveness of the remedy. As identified by the CC both HCA and BMI have relatively high prices currently and the new owners would be able to protect the prices being charged for 18 months. If AXA PPP wanted to exert downward pressure on prices during this period it would only be able to do so with non divested facilities.
37. This requirement will have the effect of ensuring that BMI and HCA can extract maximum value from the sale of their facilities. Consequently the higher prices they are currently

charging will benefit BMI and HCA in the price they achieve on sale and effectively reward them for the prices they have both been extracting.

38. AXA PPP believes that the time period to retain the contract intact should be reduced to a shorter period of 12 months.

Review of PPU arrangements

39. AXA PPP welcomes the CC's provisional decision to require parties to arrangements to operate PPUs in NHS hospitals to pre-notify those arrangements to the OFT² for review under Part 3 of the Enterprise Act 2002 (the "Act"), where there is a 'relevant merger situation' or in accordance with a 'competition test'.
40. Overall, AXA PPP believes this remedy will assist to facilitate new entrants to partner with NHS Foundation Trusts to operate PPUs. New entrants in this context can mean both complete new entrants to the UK private hospital market or, perhaps more likely, an existing operator that is not present in the local market in which the PPU operates. AXA PPP further urges that this should apply to existing arrangements where there is a *prima facie* case of an adverse effect on the local market. ✕

A case-by-case assessment is a proportionate approach

41. AXA PPP agrees that a case-by-case assessment rather than outright prohibition from operating a PPU in local areas where existing private hospital operators face weak competitive constraints is an appropriate approach. Questions of market definition/catchment i.e. whether and how closely the PPU competes with hospitals controlled by that operator, are complex, and competitive conditions in local areas change over time. The flexibility of case-by-case assessment will allow the OFT/CMA to consider the 'effect' of the proposed arrangement at the time a PPU contract is tendered by an NHS Foundation Trust. AXA PPP believes that this should be an open process, allowing representations from interested parties.

Assessing the 'effect' of a PPU arrangement in the relevant local area should be paramount

42. AXA PPP believes that assessing the competitive 'effect' of a PPU arrangement in a local area rather than the form of the arrangement should be of paramount consideration.
43. Where the award of a PPU contract to a private operator constitutes a 'relevant merger situation' qualifying for review, this should be considered in accordance with Part 3 of the Act. However, AXA PPP notes that recent arrangements were found to be structured in such a way so as not to constitute a relevant merger situation.³
44. In conjunction with the merger control rules, AXA PPP believes the introduction of a 'competition test' under a pre-notification regime would discourage parties from structuring PPU agreements, such as by way of partnership or other business arrangement, so as to circumvent the application of the merger control. Moreover, even if there is no 'intent' to circumvent, and even if the NHS favours that particular provider, the award of a PPU contract to an operator with incumbent hospital(s) in the same geographic area may be clearly anti-competitive relative to operation of the PPU in the hands of a new entrant: it could mean the difference, at the extreme, between monopoly and effective competition. As the CC is aware,

² And in the near future, the Competition and Markets Authority ("CMA").

³ See for example ME/5641/12 *Anticipated lease by HCA International Limited ("HCA") of premises from Guy's and St Thomas' NHS Foundation Trust ("G&T")*, 30 October 2012, at paragraphs 18 and 20. The OFT concluded the arrangement only involve a lease of space; no staff, customer assets or liabilities would transfer from G&T; no services or patients would transfer to HCA; and G&T would be able to continue to provide its existing (limited) private services.

AXA PPP was and remains of the view that HCA's operation of the G&T PPU was anti-competitive relative to any other operator, given HCA's ownership of, inter alia, the London Bridge Hospital (see also paragraphs 27 et seq above).

Public procurement rules do not frustrate the effectiveness of the remedy proposal

45. The EU procurement rules and the implementing UK legislation establish a legal framework governing the procedures and principles for the award of public contracts. This framework is intended to ensure that contracts awarded by a contracting authority are awarded fairly, transparently and that all potential providers are treated equally and in a non-discriminatory way.
46. Procurement law is designed to protect the integrity of the procurement process and promote economic decision making among public authorities. Procurement law does not frustrate competition policy and the application of the EU and UK competition law regime.⁴

A 'competition test' complements the merger control regime

47. As set out above, AXA PPP supports the pre-notification of all PPU arrangements to the OFT/CMA for review. Where these arrangements are not reviewed under the merger control regime, we consider the application of a 'competition test' equivalent to the 'substantial lessening of competition' ("SLC") test (i.e. a comparison of the prospects for competition with and without the PPU being operated by the relevant supplier) to be appropriate. In this case, if it is clear that the PPU contract will be awarded, and it is simply a question of to which operator, then the OFT/CC's approach to merger control in rail franchises cases is a good guide (i.e. the counterfactual used is an operator that raises no competition issues or whose issues have been 'cured'). If the evidence from the NHS and potential alternative operators (and other interested parties) is sufficiently compelling that, without the operator in question, there would be no operational PPU at all, then analogies from the merger guidelines would also work flexibly and well in capturing this situation (analogous to failing firm/counterfactual cases).
48. AXA PPP considers the application of a 'competition test' to be appropriate for the following reasons:
 - The application of a test equivalent to the SLC test would dis-incentivise parties from structuring PPU arrangements so as to 'cherry pick' the most advantageous review mechanism.
 - A competition test is a most comprehensive means for assessing the 'effect' of the proposed PPU arrangement and would enable all relevant factors to be taken into account in the competitive assessment.
 - From an enforcement perspective, a competition test is capable of ready implementation. As suggested above, existing guidance from the relevant competition authorities on the application of the SLC test and enforcement history is informative of how a competition test would be applied. Advisers familiar with UK merger control would therefore be well placed to counsel PPU operators, and face no peculiar uncertainties about how the test will work.
49. AXA PPP notes that at paragraph 2.251 of the PDR, the CC welcomes views from interested parties on the inclusion of either a 'safe harbour' provision or de minimis exemption.

⁴ CC's PDR paragraph 2.229

50. In AXA PPP's view the competition test should apply to *all* proposed PPU arrangements and makes the following observations:
- Assessing the competitive 'effect' of PPU arrangements should be of paramount consideration. This necessarily involves a detailed assessment of the likelihood of competition concerns arising from the proposed arrangements.
 - Under the CC's proposed Order, the OFT/CMA will be able to review arrangements for the operation of PPUs by private hospital operators under either existing merger control provisions if it constitutes a relevant merger situation. Alternatively, if the arrangements do not create a merger situation, the OFT/CMA will assess the arrangements applying a competition test. These are alternative tests, so that if a PPU arrangement did not qualify for review under the merger control regime, it would nevertheless be subject to review applying a competition test. Including a 'safe harbour' provision into the competition test would frustrate this objective.
51. AXA PPP also considers that the introduction of a *de minimis* exemption from OFT/CMA review is inappropriate. The introduction of any contract value threshold, at this stage, would be arbitrary and is likely to be easily circumvented through a creative repositioning of the contract.

Prohibition and restrictions on clinician incentive schemes

52. AXA PPP agrees with the CC that incentives to doctors harm competition. It concurs with the CC's view that such incentives lead to increased investigation and treatment. The presence of incentives therefore produces consumer detriment.
- Ambiguities and unduly lenient treatment of 'indirect' incentives creates an overwhelming risk of ineffectiveness of the remedy*
53. In the CC's understandable attempt to strike a balanced approach, AXA PPP has serious concerns that the CC's proposed approach carries a number of compelling risks of circumvention of and therefore ineffectiveness of the remedy, most notably in relation to "indirect incentives" including the issue of equity ownership. While AXA PPP fully understands and supports the case for the application of two exceptions for bona fide business activities, there are appropriate ways of dealing with these exceptions that do not pose the same circumvention risks that exist in the provisional remedies proposal as currently crafted.
54. AXA PPP considers that, with a number of specific exceptions discussed below, there are no legitimate grounds for a hospital group to make a payment (in cash or kind) to a consultant, and accordingly that the default position should be that all such payments be prohibited. Absent one of the legitimate exceptions discussed below, the overwhelming presumption must be that any transfer of value from a hospital to a consultant is ultimately motivated by the requirement, obligation, expectation, or prospect that the payment will influence, sway or steer, the judgement of the consultant, and that as a result he will be more likely to make a referral to the hospital in question than in the absence of such payment, and less likely to make a referral to a different hospital.
55. In particular, the CC's distinction between direct and indirect incentives is well intentioned in terms of proportionality but is fundamentally misconceived, because a remedy that permits indirect incentives is ineffective. The CC takes a more limited remedial approach to indirect incentives, understood as "where there is no linkage between an individual clinician's behaviour and the reward he or she receives" (CC PDR para. 2.368). At a basic conceptual

level, a reward tends to influence behaviour. Otherwise it is not a reward. Any profit-maximising entity (hospital group) paying the reward is doing so in the expectation that it rewards behaviour; it is not a charitable donation. Therefore, any "safe harbour" attaching to the incentives remedy should be based on considerations other than a distinction between direct and indirect incentives if the risk of wholesale circumvention of the CC's remedy is to be avoided or mitigated.

- 56. More fundamentally, AXA PPP considers that safe harbours are inherently risky in that they quickly become the foundation of or ingredients of avoidance strategies. By contrast, no genuinely bona fide activities need fear intervention because of the lack of an absolute safe harbour. The CC may wish to consider the attached email [X](#).
- 57. Accordingly, AXA PPP is firmly of the view that nothing less than a total and unequivocal prohibition of incentives of any kind will remove this problem. AXA PPP considers that the CC should demand that the source of a doctor's income in private practice comes *only* from the fees they charge to patients. Without this AXA PPP believes hospitals and doctors will devise ways to circumvent restrictions and develop mechanisms that achieve the same ends as incentives do currently. AXA PPP believes the exposure of these incentives has led to some hospital groups recognising the damage they cause and welcomes those which have withdrawn them and argue for their prohibition. Those who continue to argue for the retention of incentives, in some form or other, expose their desire to continue with this inappropriate practice in order to defend their business model.

Evidence supporting circumvention risk

- 58. AXA PPP believes that its concerns in this regard are well-grounded. In particular the CC should be aware that HCA has put on record in the HCA group's March 2011 share issue prospectus, page 18⁵ the following remarks on its approach to compliance with US regulations on incentives:

"Among these laws are the federal Anti-kickback Statute, the federal physician self-referral law (commonly called the "Stark Law"), the federal False Claims Act ("FCA") and similar state laws. We have a variety of financial relationships with physicians and others who either refer or influence the referral of patients to our hospitals and other health care facilities, and these laws govern those relationships. The Office of Inspector General of the Department of Health and Human Services ("OIG") has enacted safe harbor regulations that outline practices deemed protected from prosecution under the Anti-kickback Statute. While we endeavor to comply with the applicable safe harbors, certain of our current arrangements, including joint ventures and financial relationships with physicians and other referral sources and persons and entities to which we refer patients, do not qualify for safe harbor protection. Failure to qualify for a safe harbor does not mean the arrangement necessarily violates the Anti-kickback Statute but may subject the arrangement to greater scrutiny. However, we cannot offer assurance that practices outside of a safe harbor will not be found to violate the Anti-kickback Statute. Allegations of violations of the Anti-kickback Statute may be brought under the federal Civil Monetary Penalty Law, which requires a lower burden of proof than other fraud and abuse laws, including the Anti-kickback Statute.

Our financial relationships with referring physicians and their immediate family members must comply with the Stark Law by meeting an exception. We attempt to

⁵ http://www.nasdaq.com/markets/pos/filing.ashx?filingsid=7440880#Y83802A2SV1ZA_HTM_Y83802102

structure our relationships to meet an exception to the Stark Law, but the regulations implementing the exceptions are detailed and complex, and we cannot provide assurance that every relationship complies fully with the Stark Law. Unlike the Anti-kickback Statute, failure to meet an exception under the Stark Law results in a violation of the Stark Law, even if such violation is technical in nature."

59. AXA PPP considers that this passage makes abundantly clear that at least one subject of any anti-incentive remedy implemented by the CC will surely seek to circumvent the practical effect of the remedy, and will not hesitate to use any ambiguity to support such a strategy, nor will it worry unduly about the risk of being found in breach. Moreover, experience from the USA suggests that determined parties will seek to engage in a wide range of workarounds⁶. Accordingly, AXA PPP considers that the anti-incentive remedy needs to be structured in such a way that it is robust to "entrepreneurial" or "creative" attempts at circumvention.

Closing potential loopholes in the proposed remedies

60. The Commission states in 2.382 of its PDR that:

"We thought that any scheme operated by a private hospital operator, whether contractual or not, which provided an inducement to, or created an obligation on, a clinician to treat or refer patients for tests at its hospital or hospitals should be prohibited outright. For the avoidance of doubt we would include here arrangements which are caveated with an overriding obligation always to act in the patient's best medical interests or adhere to GMC guidelines on good practice. We considered that such arrangements inevitably create a tension between the clinician's professional obligations to his patient and his financial interest and distinguishing between referral behaviour driven by one or the other would be very difficult in practice. We therefore decided that an outright ban would be the simplest and most effective way of solving the competition problems arising from these arrangements."

61. Whilst AXA PPP agrees with the broad thrust of this statement, it considers that further tightening is required, and that (with the limited exceptions set out below) all transfers of value whether in cash or in kind, whether contractual or discretionary, whether upfront or retrospective, whether a positive transfer to the consultant or by forbearance or non-enforcement of a debt, are prohibited.
62. Moreover whereas the text in 2.382 may be seen to suggest that what is prohibited is "payment that induces", AXA PPP considers that all payments by their nature and of their essence induce, influence, steer or distort. Accordingly AXA PPP urges the Commission to remove any ambiguity by stating that what is prohibited are transfers of value in and of themselves, and that the inducement effect does not have to be proven but can simply be inferred. Failing that, AXA PPP considers that the CC should expand the set of "prohibited verbs" to ensure that a workaround cannot be predicated on a narrow interpretation of one word.

The problem of indirect incentives

63. As noted above, an important related concern is the CC's concept of direct and indirect incentives. Whilst it is, we think, common ground that direct incentives are prohibited, AXA PPP has concerns about the CC's reference in 2.368 to "schemes or arrangements between a

⁶ <https://oig.hhs.gov/fraud/enforcement/cmp/kickback.asp>

hospital operator and clinicians where there is no linkage between an individual clinician's behaviour and the reward he or she receives." If the CC were minded to allow such indirect incentives, AXA PPP considers that it is fundamentally mistaken, for at least two independent reasons:

- The first is the failure to recognise that except in the very short run the composition of the group that is rewarded is not static, that membership of the group that receives the reward is in the gift of the provider, and in particular that some form of cut off will inevitably be used as to who is included in the group. Thus, although the incentive is less sharp than direct "piece rate" linkage, the incentive is still present because individuals will wish to remain in the rewarded set.
- Second, when the linkage is not pro rata to contribution, whilst it is true that there is a shared fate of the (participating) members, social and group incentives operate to ensure action for the benefit of the group. This is particularly so where consultants in private practice at a particular private hospital will typically be in hierarchical relationships with each other in their NHS careers. Accordingly, whilst indirect incentives may be less stark than direct incentives in relative terms, in absolute terms they will still be likely to influence referral patterns, and the only solution is to prohibit payments / transfers of value.

Equity ownership

64. AXA PPP is very concerned that the CC, by allowing some exceptions regarding ownership and equity, will allow the remedy to be circumvented and that it will ultimately fail. The CC proposes that ownership of up to 3% should be allowed if purchased by specialists. However 3%, whilst appearing small, would allow groups of less than 20 specialists to own half of a hospital they exclusively refer to. The fact that specialists have paid what could be a substantial amount of money to buy this 3% does not remove the harm such an ownership has, rather it exacerbates it in that they are even more likely to ensure patients use this facility to maximise income and ensure their co-partners do the same.
65. In these circumstances AXA PPP believes that an additional monetary limit of £5,000 per consultant should also be applied, with the lower of 3%/£5,000 being the operative limit.
66. For the avoidance of doubt AXA PPP requests the CC to state unequivocally that the exclusion of incentives applies to any medical facility and any medical service. Thus AXA PPP wishes the CC to affirm that the prohibition of any payment also applies to out-patient facilities and diagnostic facilities. In addition this prohibition must extend to any related organisation or affiliations that doctors may have and ownership through other family members. This would, for example, stop hospitals making payments through companies or organisations set up by a doctor or groups of doctors.

Countervailing evidence on the alleged benefits of indirect incentives

67. AXA PPP does not share the view that doctors having financial interests in facilities is for private patient benefit. Indeed the suggestion that doctors are more interested in quality of care because they have a financial interest is a worrying one. A counter argument is for example that a doctor may be disinclined to whistleblow against malpractice or medical problems in a hospital if, as an investor in that hospital, he stands to lose significant wealth were the hospital to be fined or to lose customers. AXA PPP remains of the firm view that all incentives including ownership and equity are contrary to the interests of patients treated privately. It has long held the view that, for example, the Circle model is contrary to the

interests of private patients. AXA PPP views it as a commercial model built upon financial incentivisation.

68. In the CC's PDR Circle is quoted as referring to the McKinsey quarterly report⁷ as giving support to doctors' involvement in health care facilities leading to improved quality. This McKinsey article actually looks at the issue of doctors in management and leadership roles. The examples it quotes are from NHS public services and integrated managed care organisations such as Kaiser Permanente. These are very different environments to a fee for service model as practiced in the private sector in the UK. This report does not even purport to provide evidence to support that doctors' ownership is a positive benefit. Instead, AXA PPP draws the CC's attention to a more recently produced report (July 2013) by the US Centre for Health care Research and Transformation.⁸
69. The conclusion of the report is: "For decades physician ownership has caused many to worry that profit incentives could negatively affect the care patients receive. Today, a substantial body of research shows that ownership and self-referral are associated with increased utilization and higher system costs, low same-day referral, and diversion of [unprofitable] complex patients and Medicaid beneficiaries away from physician-owned facilities. More research is needed to support the claim that specialization of hospitals and outpatient services improves quality or patient outcomes. Important provisions in the ACA (Patient Protection and Affordable Care Act, 2010) substantially strengthen existing laws against physician self-referral by both deterring future growth in ownership and by providing patients with more information about options for services."

Legitimate exceptions to the general prohibition on value transfers

70. AXA PPP has noted above limited exceptions to the absolute prohibition on transfers of value. The two exceptions relate to the bona fide offering of genuine employment by hospitals, and to the provision of facilities, such as consulting rooms. We deal with these in turn.
 - (a) *Exception 1: Employment*
71. AXA PPP recognises that hospital groups may have bona fide grounds for wishing to seek advice from experienced medical practitioners, including those who have active and ongoing medical practices. There is in principle no objection to such individuals being employed on normal and reasonable terms. However there is a concern that such arrangements could be used as a reward mechanism, for example by attaching an elevated remuneration to such positions, and by offering them to individuals who do, or who recently have, generated large volumes of business for the hospital group in question.
72. To deal with this AXA PPP considers that if any payments to doctors are made these should be publicly displayed, including a clear statement of the responsibilities, the time input and the total remuneration. Whilst not preventing abuse, this remedy provides the transparency necessary to help detect abuse were it to occur.
73. AXA PPP further recommends that the CC instructs the GMC to require all doctors disclose to the GMC anything they receive in any way connected to their role as a doctor that is not a fee charged to a patient. This declaration should be easily accessible on the GMC website and any failure to disclose by a doctor should result in suspension pending investigation and may result in removal of licence to practise. This remedy will help to address payments from other

⁷ http://www.mckinsey.com/insights/health_systems_and_services/when_clinicians_lead

⁸ <http://www.chrt.org/public-policy/policy-papers/physician-ownership-in-hospitals-and-outpatient-facilities/>

organisations such as pharmaceutical companies and device manufacturers (eg hip replacement prostheses or pacemakers which are expensive, and are chosen by the specialist.). Payments to doctors from device manufacturers are opaque in the UK. AXA PPP has previously guided the CC to requirements for transparency that are being introduced in the US. This followed action from US federal government which sought damages from device manufacturers for increased costs on Medicare and Medicaid as a result of payments to doctors. In settlement, device manufacturers agreed to pay fines of £150 million in relation to kickbacks to doctors.⁹

74. AXA PPP draws the CC's attention to an article in the Health Service Journal of 2 August 2013 regarding inflated costs of orthopaedic devices to the NHS (see Annex 2). In this article the deputy head of procurement at the Department of Health, John Warrington, has a number of statements attributed to him. First, that "collusion between doctors and suppliers' sales representatives had led to a situation where orthopaedics suppliers had twice the profit margin of other industries" and second, that "In orthopaedics there's a huge waste in the system because of the relationship between industry and the NHS, particularly clinicians". AXA PPP believes incentives exist in the private market distorting the market for devices and increasing costs to consumers. The declaration of payments would at least shed some light on this activity.

(b) Exception 2: Consulting rooms and secretarial support

75. The second exception relates to provision of services connected with the consultant's work such as provision of consulting rooms and secretarial support. AXA PPP agrees in principle with the CC that such services should be provided only at fair market prices. That said, AXA PPP considers that this remedy is not as simple in practice as it is in theory. In particular, the level of a fair market rent is not a precise science, and the practice of a consultant can be significantly disrupted if he were forced to vacate consulting rooms at short notice. Accordingly, AXA PPP considers that rent reviews should be conducted on an aggregate basis by external valuers, with rent rises applied on a uniform basis, and where consultants in good financial standing have a right of first refusal to continue to rent their consulting room the following year. In essence the hospital should be required to act like a disinterested landlord.
- ☒.

Publishing of information on hospital and consultant performance

The information remedy remains problematic

76. AXA PPP agrees with the CC that there is a lack of information to enable consumer choice. However it believes the provision of such information is problematical and indeed there are aspects of it that it may not be possible to remedy, in particular those caused by low volumes of activity and hence unreliable data. AXA PPP considers that the CC, in its desire to address the problems caused by lack of quality information, has proposed a remedy which is both costly and unlikely to solve the problem.
77. The NHS is spending considerable sums on collecting data with the aim of improving performance. These initiatives are however at an early and developmental stage and will need evaluation. The CC has failed to appreciate that the initiatives, for example in cardiothoracic surgery, are aimed at identifying possible poor performance by hospitals and

⁹ <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2094199/>

specialists to enable further audit. These initiatives are absolutely *not* about creating a league table of performance to allow consumers choice based on these performance measures. Indeed, in examining the information available for mortality from cardiothoracic surgery it would be misleading to make judgements about the relative performance of these hospitals. This is in an area of surgery where mortality risk is small in absolute terms but relatively large compared to other operations. In addition the number of operations of each type performed by surgeons is relatively high.

78. Even so analysis of all UK data does not allow a distinction in performance to be made between hospitals or surgeons other than at the extreme of the distribution where further investigation is directed to. The problem comes down to the fact that the number of operations that need to be performed in order to distinguish random variation from a variation in performance between providers is extremely large. To believe that it is possible to make distinctions in outcomes in the private sector with far fewer operations per surgeon and per hospital for operations with low mortality is misplaced. For further discussion on this matter we refer the CC to an article published in the Lancet.¹⁰

OPCS codes are not suitable and will generate additional costs

79. The PMI insurers use CCSD coding as a means of reimbursement. AXA PPP's rapid view is that a move to OPCS coding will cost it at least £> in changing its IT systems (plus ongoing costs), costs which the CC has not factored into its PDR. CCSD was derived some years ago from OPCS codes as OPCS was considered unsuitable for our billing purposes. OPCS coding has over 5,000 codes whereas CCSD contains approximately 1,500. AXA PPP believes that increasing the granularity of coding will be inflationary in claims costs through complexity inflation and unbundling (for an example of this please see Annex 3). It is noticeable that it would appear that this suggestion has most support from doctors who are the people who would not have to meet an increased cost and who are likely to stand to gain from any change as outlined above.
80. <. AXA PPP would also point out that the NHS does not use OPCS codes directly for payment. Instead it uses Healthcare Resource Groups (HRG) derived from combinations of these codes as well as other factors such as complicating conditions, age and setting of treatment. OPCS codes are not updated as frequently and speedily as CCSD codes with the result that a move to OPCS will slow coding for new treatments as they come along.

ICD coding is of poor quality

81. The CC has also proposed that the industry moves from ICD 9 to ICD 10 and then ICD 11. The accuracy of ICD coding is extremely poor such that the vast majority of claims AXA PPP sees are classified under symptom codes rather than as specific diagnosis. To illustrate this, the top three ICD codes in AXA PPP's claims are knee pain, unspecified back ache and shoulder pain. To make ICD coding accurate and reliable would require significant investment in clinical coders in both hospitals and AXA PPP. In addition AXA PPP believes that a move to ICD 10 will require a change to its IT systems costing another £>.
82. For the reasons above AXA PPP considers the CC's proposed remedies to be not evidence-based and disproportionate. The CC has overemphasised the utility of the data collected and has not appreciated the significant other costs regarding IT systems, clinical coders and claim

¹⁰ Lancet 16th November 2013; 382: 1674-77

fee inflation. In addition there is a significant danger that data will be misinterpreted by consumers and abused by providers. Indeed if consumers, through an understandable lack of understanding, respond to results that are not statistically significant, the remedy will lead to an artificial distortion of competition, and hence will be perverse.

- 83. Instead of the CC's proposed remedy, AXA PPP proposes that insurers and hospitals should be required to work together to look further at the issue of data collection and quality assessment. The remit of this group would be to agree what data should be collected for the benefit of consumers in exercising choice (see also paragraph 89).
- 84. In any collection and interpretation of data, judgements are made as to what to collect, how this is done, quality assurance of the data, what possible biases are and indeed what to publish. This requires both independence and consideration of utility and cost of data collection. By way of illustration, one reported outcome measure is readmission rates by hospital. For each hospital this is a relatively easy measure to collect within the hospital itself. However it is important to understand that without data identifiable at a patient level (which PHIN says it does not collect) it is subject to bias. If a patient is treated at one hospital and has a complication needing admission, they may well be admitted to another hospital. Hence without the ability to link these episodes a true picture of rates is not obtained. This bias will be more pronounced if the readmission is as an emergency when private hospitals may not be involved as they are not set up to handle emergency cases. In addition, if a patient travelled to Central London but lived some distance away, they would not travel to Central London as an urgent case. Thus a body looking to collect this information needs to have the capacity to link individual patients across providers and across public and private sector. This example illustrates why such a body needs independence and skill so that bias in data is recognised and its limitations understood. Otherwise it is too easy to influence what is collected and its interpretation by those with a vested interest.

PHIN is not a suitable information organisation

- 85. ~~☒~~. Therefore AXA PPP disagrees with the CC's view that PHIN with an expanded membership base is a suitable information organisation. AXA PPP believes a fresh organisation is needed. Of existing information organisations, AXA PPP considers that Dr Foster would be a much more appropriate body commanding greater ~~☒~~ and expertise than PHIN. Collaboration with the NHS Information Centre would also be a better alternative and may help address a funding issue highlighted below. In addition both Dr Foster and the NHS Information Centre are in a better position to analyse the full patient journey and to ensure consistency with NHS data.

Funding

- 86. The CC has proposed that there is joint funding between insurers and hospitals. AXA PPP considers this to be a very unusual situation, in that it requires consumers to pay for the provision of information thought needed to exercise choice. The choice of funders leaves out a major player in commissioning private provision, namely the NHS. The CC will be aware that NHS activity is a substantial part of the activity of some private hospitals. An example is that the NHS purchases over half of all joint replacements provided in private facilities. In addition self- pay patients would avoid the additional costs of information provision.

AXA PPP's recommendations

- 87. AXA PPP is absolutely in favour of provision of meaningful information that helps consumers to make informed choices. AXA PPP is concerned though that the CC has not appreciated the problems of providing such data and considerably underestimated the costs that its proposed

information changes will require. Whilst the CC's provisional recommendations are well intentioned AXA PPP believes the CC has proposed a solution which imposes considerable costs, which will be ultimately met by consumers, and with insufficient analysis of the data problems.

88. AXA PPP further believes that the CC should not recommend that the industry move away from CCSD coding for billing purposes nor imposes a move to ICD10 coding.
89. Nevertheless AXA PPP is extremely keen that any opportunities to provide information to consumers around quality of providers are not missed. For this reason we propose that an independent group be formed, funded exclusively by a levy from hospitals and insurers, to address this important issue. Representation on the group should come from hospitals and insurers. In addition it should also include experts in epidemiology and statistics, together with representation from a patient body with recognised authority and legitimacy. This group would be tasked with making, within a time-boxed period of say a maximum of one year, recommendations to the CMA regarding what data should be collected and how it should be presented to inform consumer choice, together with a realistic implementation plan.

Providing consultant fee information

90. AXA PPP agrees with the proposals that specialists should be clear on their charges. It believes this should be as comprehensive as possible and be before patients have seen or require the services of anyone who seeks to charge them. AXA PPP considers that this may lead to higher charges, as lack of information on which to judge quality and price means that higher price equates with higher quality. However, the alternative of a lack of transparency cannot be condoned.
91. AXA PPP does not agree with the CC findings that consultants would find it difficult to provide information on levels of fees in advance. It believes it is perfectly possible for specialists to be transparent on their fees for the common procedures they perform, which in most cases will be a relatively small number. Indeed without the publication of such information the only information that is transparent to a customer is for consultations. This is of very limited benefit to consumers as they will have no idea what level of fees the specialist charges for procedures until they need this. They will then at this point have difficulty in making any comparison to what other specialists might charge as these will not be readily available. Finally publishing just consultation charges will continue to allow anaesthetists' charges to be hidden until point of need.
92. AXA PPP therefore believes the CC should change its recommendation and require specialists to make prices publicly available for their most common procedures on the hospital's website and their own. It also believes that this fee should identify the level of anaesthetic fees for these procedures as well.

List of Annexes

1. ✗
2. Health Service Journal 2 August 2013 – article “DH blames collusion for excess orthopaedic costs”
3. ✗