Private healthcare market investigation

Response to Provisional Decision on Remedies

Bupa Health Funding

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1. INTRODUCTION

1.1 The Competition Commission's Provisional Decision on Remedies ("PDR") presents the measures that the CC proposes to address the five Adverse Effects on Competition ("AEC") identified in its Provisional Findings ("PFs")[1]. These remedies revise and amend the remedy options the CC set out in its Remedies Notice, which was published for consultation alongside the PFs.

1.2 Bupa Health Funding ("BHF") welcomes the opportunity to comment on the proposed remedies in the PDR.

1.3 The paper is structured as follows:

- Part 2 sets out our general comments on the remedies package as a whole.
- Part 3 comments on the nine hospital divestments proposed by the CC.
- Part 4 comments on the 'market opening' remedy related to NHS Private Patient Units ("PPUs).
- Part 5 comments on the clinician incentives remedy.
- Part 6 comments on the package of information remedies.

1.4 BHF has already submitted a separate paper[2] focussing on the CC's proposal for OPCS-4 procedure coding to replace CCSD procedure coding by April 2019. BHF has major concerns that the CC has not fully considered the substantial costs and harm for the industry that will arise from this change. In our view, the proposal is unworkable, disproportionate, not well targeted at an AEC identified in the PFs, and so must be removed.

1.5 Please note this submission contains commercially sensitive information about BHF's strategy and critical trading partners that should not be shared with other parties without BHF's prior written consent. A non-confidential version will be provided to the CC for publication on its website.

[1] PFs published by CC on 2 September 2013. PDR published by CC on 21 January 2014.
[2] "BHF response to Provisional Decision on Remedies related to reimbursement coding", 11 February 2014

2. GENERAL COMMENTS ON THE CC PACKAGE OF REMEDIES

2.1 The package of remedies proposed in the PDR is an important and necessary step forward. However, BHF remains concerned that the package as a whole is not sufficient to address the substantial challenges facing the sector. The package leaves significant customer detriment unresolved. The CC must consider more far-reaching steps.

2.2 In this section we first explain why there are concerns that the remedy package does not go far enough. Second, we explain remedy options that BHF believes the CC should further consider.

EFFECTIVENESS AND PROPORTIONALITY OF PACKAGE AS A WHOLE

2.3 Table 1 summarises, at a headline level, the proposed package of remedies the CC is recommending to address the five AECs identified in the PFs (please note, we explain our more detailed views on each remedy in the later sections of this report).

Table 1: High level summary of measures and intent

	Measure	Targeted outcome
A	Nine hospital divestments – 2 from HCA in central London and 7 from BMI (Remedy 1 in the Remedies Notice)	Enhance rivalry and choice directly in affected cluster markets. This would lower prices and improve quality/innovation in certain specific markets
B	Apply a competition test to private hospitals entering into management arrangements with PPUs (Remedy 3 in the Remedies Notice)	Enhance prospect of future competition in local markets by increasing the likelihood that a new entrant can manage a local PPU rather than the incumbent private hospital foreclosing entry through partnering with the PPU. This would slightly reduce entry barriers
C	Restrictions on private hospitals offering incentives to clinicians (Remedy 4 in the Remedies Notice)	Reduce information asymmetry for patients, make sure that patient interests are the sole driver of referrals (not financial interest), and focus hospital competition for consultants on quality alone
D	An information organisation to publish, from April 2017, activity and outcomes data on private hospitals and consultants (Remedy 5 and 7 in the Remedies Notice)	Enhance competition and choice between providers by remedying the current absence of relevant, comparable information
E	An obligation on consultants to provide fee details in writing to patients as early as possible in the treatment journey (Remedy 6 in the Remedies Notice)	Reduce information asymmetry for patients, and thereby increase competition and choice amongst consultants

2.4 Part 4 of the PDR explains the interactions of the remedies in the package. We agree that the whole package is important and necessary[3]. Each component makes an important and necessary contribution to addressing customer detriment and there are synergies between the

[3] As the CC notes "*We [the CC] do not consider that any of the proposed remedies would, in isolation, address the AECs comprehensively*" (PDR, paragraph 4.6).

individual remedies[4]. However, BHF is concerned that the combined impact of the package is insufficient, particularly in relation to addressing the market power of hospitals.

Hospital market power

2.5 The PFs found that around 100 private hospitals outside London faced insufficient competition[5]. Some ✂ of these were either Single or Duopoly facilities where choice and competition was acutely limited[6]. The CC also found a statistically significant relationship between (self-pay) price and market concentration.

2.6 However, currently, the proposed remedies package makes little or no impact on the intensity of competition in Single and Duopoly markets (where customers experience significant detriment):

- The divestment remedies do not directly affect these markets.
- The market opening remedy in relation to PPUs is welcome, but its impact will be relatively muted: (a) it is unlikely to have any impact in Scotland, Wales or Northern Ireland[7]; and (b) in England its success relies on PPUs becoming attractive entry routes which can reach a scale and scope to be effective competitors in the local market. Entrants will continue to face several other significant entry barriers identified by the CC in the PFs.

2.7 Therefore, prices to self-pay patients in Single and Duopoly markets are likely to continue to remain above 'competitive' levels. The large hospital groups which own these 'must have' facilities will also retain the ability to use them as a bargaining advantage against insurers.

2.8 Indeed, the package does not materially rebalance the bargaining position between large hospital groups and insurers. The PFs found that the largest hospital groups - BMI, Spire and HCA - had market power over insurers (particularly smaller insurers, which had no buyer power whatsoever)[8]. Further, as BHF noted to the CC, there is evidence to suggest that Ramsay and Nuffield also enjoy positions of market power. Ramsay earned excessive profits in 3 of 5 years studied by the CC. ✂.

2.9 Yet the proposed remedies will have the following impacts:

- The Spire, Ramsay and Nuffield portfolios are left unchanged. ✂ of BHF's spend with Spire remains in hospitals in Single/Duopoly markets[9]. ✂ of BHF's spend with Nuffield remains at hospitals in Single/Duopoly markets. Indeed, as the CC has not restricted these groups from buying the divested assets from HCA or BMI, there is a risk that these providers could actually grow in scale. So insurers' bargaining power will not be materially improved against these three large groups.

[4] We agree, for example, with the CC's example that the effectiveness of the divestment and PPU-expansion remedies would be undermined if they were not supported by the remedy restricting clinician incentives.
[5] BHF Response to Remedies Notice, Table 1.
[6] We base this estimate on the classification of hospitals provided to BHF during the put back papers in May 2013. Some of the CC's classifications may have moved on from this date. However, we assume the list is still broadly representative.
[7] See PDR, paragraph 2.253: "…*currently, health policy in Scotland, Wales and Northern Ireland makes it unlikely that PPUs will be launched there*".
[8] PFs, paragraph 41 (page 10).
[9] BHF claims expenditure in 2012.

- The CC has proposed seven areas in which BMI must divest a hospital, but in five of these areas it is giving BMI discretion over which of two possible hospitals it may wish to divest. Assuming that in each case BMI chooses the smaller of the two in that cluster, the combined impact of the seven hospital divestments will be a reduction of BMI's total scale by only ✂ (in BHF revenue terms). BMI will retain ✂ Single hospitals and ✂ Duopoly hospitals. ✂. Indeed, it could even grow in scale and market power if it is allowed to buy HCA's divested facilities in central London. Therefore, while the remedies will impact on BMI's market power against insurers, it is very unlikely that this impact will be sufficient to bring BMI pricing down towards competitive levels.

- The HCA divestments provide a significant positive step in improving insurers' choice of hospitals in central London. However, HCA will remain significantly larger than any other central London competitor and it is expanding further[10]. It will retain dominant positions in ✂ [11]. Therefore, while the divestments improve bargaining position for insurers, they do not neutralise HCA's significant market power.

- Hospital groups will still be able to use tying tactics in negotiations with insurers, as the CC has not proposed any alternative to the two discarded "no tying" remedies (Remedies 2(A) and 2(B) from the Remedies Notice). Groups will therefore still be able to use their 'must have' facilities to leverage inclusion of all of their facilities in insurer networks and to punish insurers which delist poorly performing parts of their portfolio.

- The Information remedy proposed by the CC will improve the potential for competition and choice between hospitals. However, it will take significant time for the effect of this to be felt[12]. It may be only in April 2017 that comprehensive information is published by the information organisation. Further, where hospitals retain the upper hand against insurers, either in specific local markets or at a group level, they will prevent insurers from using the information effectively in negotiations. For example, if the group is able to tie its hospitals together as a block in a negotiation or network tender, then the insurer may have little chance to use any information on the relative quality of hospitals within the group's portfolio.

2.10 In summary, the bargaining power of hospital groups is not sufficiently addressed. Insurers and self-pay patients will still not have sufficient buyer power to drive value for money in a sector facing a serious affordability crunch.

2.11 The impact of the package can also be assessed by how effectively it addresses customer detriment.

2.12 The CC provisionally found substantial customer detriment of between £173 million and £193 million per annum between 2009 and 2011 due to the market power of the largest three hospital groups – HCA, BMI and Spire[13]. Further, this estimate was conservative because:

[10] For example, in November 2013 it was announced that HCA would be taking floor in the Shard to establish a private clinic (see http://www.ft.com/cms/s/0/943945ce-4864-11e3-a3ef-00144feabdc0.html#axzz2ry8T11Yf).
[11] BHF Response to Remedies Notice, Figure 8.
[12] The CC recognises this point: "Our information remedies, however, may take longer [than two to three years] to affect patient and GP behaviour, as they become familiar with them over time" (PDR, paragraph 4.32).
[13] Over the full five years assessed by the CC, 2007 to 2011, consumers had incurred detriment of just under £1 billion (in 2013 money) due to the excess profits earned by these three groups.

- It used a cost of capital at the top end of the range considered by the CC, thereby minimising the differential between ROCE and cost of capital used in the detriment calculation[14]. Using a lower cost of capital benchmark would increase the detriment.

- The CC excluded from its calculations the EBIT and capital employed earned from NHS activity. The allocations between NHS and private work are driven by revenue. However, as margins are lower on NHS work than private work, this revenue allocation rule would over attribute EBIT to NHS activity and so understate the excess profits earned from private customers.

- It excluded the excessive profits earned by Ramsay in 3 of the 5 years looked at by the CC.

- The recession suppressed private patient demand. In a period of more 'normal' market conditions, prices and profits would likely be even higher.

- It did not capture the welfare losses of those customers excluded from the private healthcare due to high prices over the period. For example, over the same 5 years of excess profits analysed by the CC, over 700,000 people exited the PMI market[15].

2.13 In the PDR the CC calculates the present value of benefit to customers from its proposed remedies by taking a present value of the annual benefits over the next 20 years using the discount rate of 3.5%[16].

2.14 Using the same logic, were the CC to design a remedies package that fully resolved the customer detriment then customers could benefit by, conservatively, £170 million per annum. Over a 20 year period this would result in cumulative benefit of around **£2.4 billion** in present value terms. This estimate may be significantly understated given: (i) the conservative nature of the inputs into the customer detriment calculation, (ii) the estimates do not take into account any benefit to patients arising from an increase in demand resulting from the lower prices charged and higher quality of care offered (as a direct consequence of the package of remedies)[17] and (iii) the estimates ignore the wider benefits to the UK healthcare system as a whole from a well-functioning private healthcare sector.

2.15 Clearly, some offsetting costs (both one-off and ongoing) caused by any remedies package moving the industry to a new equilibrium would also need to be considered when assessing the likely consumer benefit. However, the assumption would need to be that these costs would be extremely high (and ongoing) to conclude that there is not the opportunity for significant net benefit for customers from a remedies package that comprehensively addressed consumer detriment.

2.16 Against this significant opportunity for consumer benefit, the likely impact of the CC's remedies package appears small.

2.17 The CC quantifies the cumulative benefit of its divestment remedy as:

[14] In contrast, in the Aggregates Inquiry (2014) the CC applied the mid-point of the cost of capital range when calculating customer detriment.
[15] Laing and Buisson, Health Cover 2013.
[16] PDR, paragraph 2.161 (e).
[17] PDR, paragraph 2.150.

- The net benefit (after costs) arising from the HCA divestment of the London Bridge and the Princess Grace hospital is estimated at £129 million in a base case (and £38 million in a downside)[18]. The CC also considers an 'upside' case if HCA prices adjust to the level of its closest competitor (The London Clinic) of between £294 million and £365 million[19].

- The net benefit (after costs) arising from the proposed seven BMI hospital divestment is estimated at £57 million in the base case (and £19 million in a downside)[20]. No upside case is presented.

2.18 Therefore, in its base case, the CC estimates customer benefits from the divestments to be roughly equivalent to that of one year of customer detriment already taking place. This is under 8% of the identified 'opportunity' for customer benefits. In a downside case it would be under 3% of the identified opportunity.

2.19 In the PDR, the CC does not explicitly value the benefits from the PPU remedy, the Clinician Incentives remedy, or the information remedies. These could be material but none of these remedies will substantially impact the bargaining power that hospitals have over insurers which is the key cause of consumer detriment that has been identified. Therefore, we maintain that the CC has not discharged its duty to address the detriment to its maximum practicable extent.

REMEDIES FOR FURTHER CONSIDERATION

2.20 The CC concludes that its proposed package "*represents as comprehensive a solution as is reasonable and practicable to the AECs and resulting customer detriment that we have provisionally found*"[21]. However, given the hospital market power and customer detriment that is not addressed by the package, we believe further consideration must be given to a number of remedies the CC has provisionally discounted.

Price control

2.21 BHF had proposed that a price control of hospitals in Single markets could (i) improve outcomes for self-pay patients and (ii) reduce the ability of groups to leverage these facilities in negotiations. We deliberately constrained the scope to only Single markets to make this measure more workable (giving a large number of more competitive markets across the UK to act as yardsticks) and proportionate. We showed also that the likely benefits for customers from this control could outweigh the (one off and ongoing) costs of setting up even a relatively large regulator, comparable to the CC, to manage the regime (although to be clear we were not suggesting a regulator of this size would be necessary).

2.22 The CC, however, dismisses the proposals in the course of six paragraphs of the PDR[22] on the basis of concerns expressed qualitatively, but with no apparent detailed exploration of options or analysis of cost/benefit. This is insufficient to discharge the CC's obligation to "*have regard to the need to achieve as comprehensive a solution as is reasonable and practicable to the*

[18] PDR, Table 6, page 2.63.
[19] PDR, paragraph 2.163.
[20] PDR, Table 6, page 2.63.
[21] PDR, paragraph 4.50.
[22] The CC briefly considers a price control remedy at paragraphs 3.89 to 3.94 of the PDR.

adverse effect on competition."[23] BHF also notes that "*the clear preference of the CC is to deal comprehensively with the cause or causes of AECs wherever possible*".[24] It is not clear that the CC has in fact sufficiently considered a comprehensive remedy (or set of remedies) to address the weak competitive constraints identified in Single and Duopoly markets – in particular, the viability of a price control remedy. We acknowledge that there are challenges to setting up an effective price control regime, but options could be considered to mitigate these risks.

No tying remedy

2.23 In the PFs, the CC found evidence that large hospital groups use the threat of price rises at their 'must have' hospitals to leverage recognition, or prevent delisting, of other facilities in their portfolios. This placed insurers at a significant disadvantage in how they use networks or negotiate better value for money.

2.24 In the Remedies Notice, the CC proposed two possible options to address this – Remedy 2(A) and Remedy 2(B). Following consultation, however, the CC concluded in the PDR that neither option as proposed would be effective or proportionate and the two options have therefore been dropped. However, the CC then fails to propose any alternative options to replace them. Therefore, an identified issue is unaddressed and insurers will remain at a disadvantage in negotiations (particularly as large hospital groups, other than HCA, will not be substantially changed in scale or ownership of must have facilities as a result of the CC's remedies package).

Divestments in non-cluster markets

2.25 In response to the PFs, BHF raised significant concern that hospital group scale itself leads to an AEC. We submitted on 6 December 2013 a paper explaining in detail why this is the case. On the basis of this concern, BHF recommended that:

i. Divestments in non-cluster areas – Single and Asymmetric Duopoly areas in particular – would significantly improve outcomes for insured patients. Post-divestment the hospital group would be smaller in scale and would own fewer 'must have' hospitals. The divested hospital, now on a standalone basis, would also likely be in a weaker bargaining position (no longer benefiting from a network effect). Therefore, the CC must consider more far-reaching divestments outside of cluster markets.

ii. The main hospital groups should <u>not</u> be allowed to purchase divested hospitals from BMI and HCA as this would simply expand their scale and strength, weakening the effectiveness of the divestment remedies; and

iii. Where the CC was considering which of two or three facilities should be divested in a cluster market, if all else is constant, the CC should recommend the larger of the facilities (thereby reducing the group's scale and so bargaining position against insurers).

2.26 The CC discounts BHF's concern and recommendations in the PDR, noting that:

[23] Sections 134(6) 138(4) Enterprise Act 2002.
[24] Sections 134(6) and 138(4) Enterprise Act 2002, and paragraph 330 of CC3 *Guidelines for market investigations*.

> *"Several parties, including Bupa and Nuffield, put forward the view that the CC should specify divestiture remedies in non-cluster areas in order to reduce the scale of some of the larger private hospital operators. This approach to remedies is not consistent with our provisional findings that the level of national prices is the result of the level of market power held by the private hospital operators in each of the local areas in which they operate rather than due to the overall scale of the private hospital group"* (PDR, paragraph 2.63).
>
> *"In effect, we found [in the Provisional Findings] that the national prices paid by insurers were equivalent to the weighted average of the local prices that they would have paid for each hospital if all prices were negotiated separately. We did not find a compelling theory, or evidence to suggest that local market power could be magnified via common ownership"* (PDR, footnote 48).

2.27 It is clear from footnote 48 that the CC has not considered the arguments set out in BHF's submission of 6 December 2013, which was in response to the PFs. These arguments illustrated why it was likely that a larger group of hospitals would have higher bargaining power (even holding constant the number of 'must have' hospitals in the group). To summarise briefly the arguments submitted in that paper:

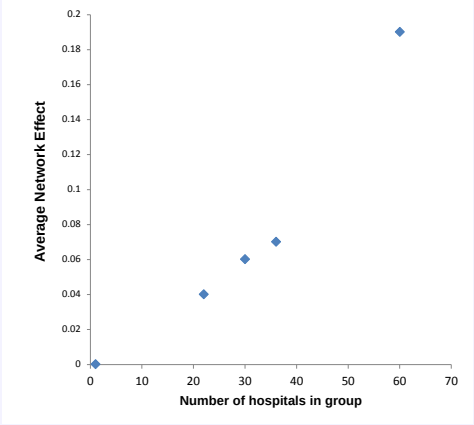
i. By increasing the number of hospitals under common-ownership, a group is able to internalise an increasing number of patients who live in 'overlap' areas between its facilities. The greater the number of overlap areas the group internalises, the stronger is its incentive to raise prices unilaterally. Indeed, the CC's LOCI metric provided a clear indication of this effect – as expected, group size is positively correlated with the estimated average 'network effect' for hospitals within the group[25]. Figure 1 below summarises the relationship.

[25] The network effect shows the increase in LOCI an individual hospital derives from being part of a larger group

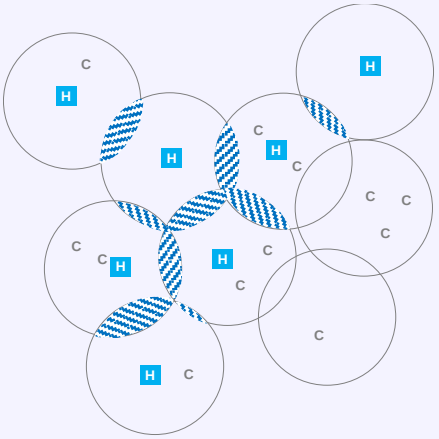
Figure 1: Relationship between group size and average network effect

	BMI	Spire	Nuffield	Ramsay	Standalone hospital*
Number of facilities	60	36	30	22	1
Average Network Effect	0.19	0.07	0.06	0.04	0

Source: Provisional Findings, Appendix 6, "Table 14: Characteristics of hospital operators' portfolios, 2011"
* "Standalone hospital" included for illustration; given it is not part of a group it would have zero network effect.



Conceptually, on the right we illustrate that as the Hospital group "H" increases the number of hospitals in its portfolio, so the areas of internalised overlaps between its hospitals grows.



ii. The number of hospitals the insurer makes available to customers has a direct impact on the attractiveness of the insurer's proposition. A large hospital group is able credibly to threaten to withdraw a significant number of hospitals from the insurer during a dispute with the insurer; thereby weakening the insurer's proposition with new and existing customers. For example, ✂.The insurer would not face this same risk of simultaneous withdrawal if the hospitals were not co-owned.

iii. Entering into a dispute with a larger hospital group has a much higher operational cost and reputational risk for the insurer. A dispute with one hospital in a local market is unfortunate but allows the insurer to concentrate all its resources on that area and it is less likely to create uncertainty and complaint from larger corporate customers and intermediaries. The costs and risk magnify, however, if the insurer is in dispute with hospitals in many locations simultaneously (something much more likely to happen when dealing with a group than with many individual hospitals). When corporates and intermediaries become concerned, the risk magnifies for the insurer that it could quickly lose significant customer volumes (even beyond those in the dispute-affected markets).

iv. Co-ownership also allows the group owner to withdraw strategically from offering certain specialisms in some of its facilities, in so doing creating concentration at the specialism level that would not arise if the hospitals were separately owned. This can make a hospital 'must have' for key specialisms in a market, further strengthening the group's bargaining position against insurers.

2.28 BHF asks that the CC urgently reconsiders these concerns.

2.29 At a minimum, these concerns should be reflected in:

i. restricting the list of suitable acquirers for the divested HCA/BMI hospitals; and

ii. the CC's considerations on which BMI hospitals should be divested in those clusters where currently the CC has suggested that it would allow BMI to make the choice. We expect BMI will choose the smaller of the two in each case. But we believe that the CC obliging BMI to divest the larger of the facilities would have a materially greater impact on future insurer negotiations with BMI group – which would deliver benefits for insured customers beyond the affected cluster market.

AECS NOT ADDRESSED

2.30 BHF is very concerned that the CC provides no further analysis of the additional AECs that BHF asked the CC to consider in response to the PFs[26]. Each has bearing on remedies design. The CC has in effect lost the opportunity to address these AECs through not proposing any measures in the PDR.

Consultant groups

2.31 In response to the PFs we explained that:

i. The CC's conclusions on anaesthetist groups did not follow from its own evidence or analysis. There was evidence of both dominance and customer detriment;

ii. The CC must consider evidence on the anticompetitive effect of consultant groups in ophthalmology;

iii. The market inquiry provides the unique opportunity to set guidelines as to how consultant groups operate in a competitive manner. Normal competition law is unlikely to be effective. The OFT is highly unlikely to prioritise an investigation into a single group. Even if an investigation were undertaken, the complainant or the OFT may struggle to prove the case of excessive pricing given the lack of transparency as to which consultants are in groups (making establishing any 'non-group' benchmarks difficult); and,

iv. There is significant risk that consultant groups will undermine the effectiveness of the remedies the CC has proposed. In particular, consultant group members have little incentive to compete with each other on price or quality.

2.32 BHF proposed remedies to assist in addressing these risks – see paragraph 1.46 of the BHF Response to Remedies Notice. However, there is no evidence in the PDR that any measures in relation to consultant groups were considered.

[26] See BHF Response to the Provisional Findings (submitted 23 September 2013) and BHF Response to Remedies Notice (submitted 30 September 2013).

Vertical mergers between hospital operators and GPs

2.33 Hospital operators are increasingly acquiring a presence in primary care; GP practices in particular. This negatively impacts both patient choice and competition. The NHS has significant concerns about vertical arrangements that may compromise the impartiality of the GPs, and it has therefore put safeguards in place, within its assessment framework for NHS mergers, to protect that impartiality. BHF recommended that similar safeguards were necessary in a private healthcare context, in particular because the OFT may be unable to establish jurisdiction to assess hospital-GP vertical arrangements under the merger control rules.

2.34 The Clinician Incentive remedy may provide some welcome safeguards for the protection of GP impartiality, through its restriction on clinician equity holdings to under 3% and its requirement that clinician interests in hospital operators be published (assuming the restrictions apply to GPs as well as consultants, which the CC needs to clarify explicitly). An additional remedy which would address this AEC would be to impose a mandatory competition test on transactions involving hospital operators and GP practices similar to that being designed in relation to PPUs.

Standardisation of coding outside of procedure coding

2.35 There is common coding across the private sector for surgical procedures and diagnostic testing through CCSD. However, these procedures account for under ✂ of spend with hospitals[27].

2.36 This means that some ✂ of spend with hospitals has no common coding architecture (each hospital operator using its own coding chargemaster). This undermines comparability between private hospitals and significantly increases insurer administration costs. BHF, therefore, asked the CC to consider measures to extend, through mandatory industry participation, standardisation into the ✂ of spend that is currently uncharted.

2.37 The CC has instead proposed to replace CCSD with OPCS. This will entail moving from a credible coding system which was specifically designed for reimbursement purposes in PH to an alternative which is not fit-for-purpose and will not facilitate effective payments in PH. It will create significant and unnecessary costs for the whole industry (as detailed in our separate paper). For example, insurers, hospitals and consultants will need to invest in new systems, re-train employees, hire specialist coders, and re-negotiate contracts. The CC's proposal seeks to change the only part of the PH system where there is effective coding and comparability. But it does nothing to increase the standardisation of coding beyond that currently covered by CCSD into the over ✂ of spend that needs standardisation.

2.38 A preferable alternative, if the CC is concerned about NHS comparability, is to require the information organisation to invest, maintain, and make available as complete a mapping between CCSD and OPCS as possible. In addition, the CC should recommend for the industry to maintain CCSD as the standard reimbursement system in PH[28].

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[27] BHF response to Remedies Notice, Table 6. An additional ✂ of BHF's expenditure is expected to be recorded under a common diagnostic coding structure that was recently launched by the CCSD group. However, even after this schedule is completely implemented, more than ✂ of BHF's expenditure is expected to remain in activity areas that lack standardised coding.

[28] See paragraphs 5.22 to 5.26 of "BHF Response to Provisional Decision on Remedies related to reimbursement coding" (dated 11 February 2014).

3. HOSPITAL DIVESTMENTS REMEDY

3.1 The CC has provisionally found that a number of features give rise to the following AECs: (i) high barriers to entry for full service hospitals; and (ii) weak competitive constraints in many local markets including central London[29]. In particular:

i. Over 100 hospitals across the UK were identified as facing "*insufficient competitive constraint*".

ii. The hospital groups of HCA, BMI and Spire were found to have market power and to be earning significant excessive economic profits.

iii. No insurer was found to have countervailing buyer power against these groups, with smaller insurers having no buyer power whatsoever.

iv. Self-pay patients were found to face significantly higher prices in concentrated markets.

3.2 In the PDR, the CC has proposed that HCA should divest two hospitals in central London and that BMI should divest seven hospitals in various local markets across England.

3.3 BHF agrees that divestments in cluster markets are necessary and should improve competition in these local areas. In particular, we welcome divestments in central London which are critical for improving competition in central London. **However, BHF believes that the CC's proposed divestitures will not be sufficient to address the AECs or to remove the detriment caused to both self-pay patients and insured customers by hospital market power**.

Divestiture remedy

3.4 The CC has proposed that BMI and HCA be required to divest the following hospitals to suitable purchasers:

i. BMI:

i. Either the Clementine Churchill or Bishops Wood hospital;

ii. Either Kings Oak or Cavell hospital;

iii. Either Chiltern or Shelburne hospital;

iv. Chelsfield Park and either Shirley Oaks or Sloane hospitals;

v. Either Saxon Clinic or Three Shires hospital; and

vi. Highfield hospital;

[29] Please note that, as set out in our response to the Provisional Findings, BHF considers it critical that the CC examines a further AEC in relation to the market power of large hospital groups – that AEC relates to the scale of the larger groups which itself confers market power against insurers incremental of the must have facilities within a group's portfolio.

ii. HCA:

i. Both the Princess Grace and the London Bridge hospitals.

3.5 The CC has discounted the need for divestments in 3 local areas which the CC consulted on at the Divestment Options stage[30]. The CC has also in many instances given BMI discretion over which hospital to divest. The CC's rationale and overview of the divestiture process is summarised as follows[31]:

i. The remedy would address directly the AEC arising from the structural feature of weak competitive constraints in local markets by introducing one or more additional competitors or strengthening existing competitors with a minor local presence. In central London, the CC considers that the proposed divestitures would enable substantially greater rivalry on price and will enhance rivalry on quality and innovation.

ii. Divestitures would take place to suitable purchasers that are independent of the divesting parties and have appropriate financial resources, expertise and assets to enable the divested hospitals to be effective competitors in their respective markets. Appropriate expertise would include expertise and experience in operating hospitals of a level of acuity and specialism appropriate to the hospitals being divested.

iii. The CC would require commitments from the divesting hospital groups not to induce consultants to move their practice to the group's retained facilities and from insurers to continue to recognise the divested hospitals on the same terms[32] for a period of 18 months following divestment.

iv. The CC would require the appointment of a monitoring trustee to oversee the divestiture process and compliance with divestiture commitments. The CC would reserve the right to appoint a divestiture trustee should divestiture not be implemented within the specified period.

3.6 **BHF has significant concerns that these divestments are not sufficient to address customer detriment or rebalance bargaining power**. We outline our concerns in more detail below.

Single and Duopoly markets

3.7 The CC's proposed remedy has little or no impact on hospitals in the significant majority of Single/Duopoly markets. BHF has estimated that Single and Duopoly hospitals account for over ✂ of the 'hospitals of concern' identified by the CC outside central London[33]. These facilities have significant market power, statistically higher prices for self-pay patients, and confer bargaining power over insurers to the groups that own them.

3.8 The CC's proposed divestitures do not directly affect the majority of Single and Duopoly markets. As a result, it seems highly likely that a significant proportion of the existing consumer detriment identified by the CC will be unresolved. Self-pay customers will continue to see detriment through prices above 'competitive' levels. Insurers will equally gain no additional buyer power in these markets.

[30] PDR, paragraph 2.95 and 2.98
[31] PDR, paragraph 7
[32] We note that prices may change as a result of increased local competition following divestments.
[33] BHF Response to Remedies Notice, Table 1.

3.9 The CC reasoned that "*divestiture in Single or Duopoly areas would not be an effective remedy since, in both cases divestiture would substitute one rival for another rather than introduce more rivalry*"[34]. However, as noted in paragraph 2.3 of its response to the CC's Divestment Options Paper, BHF disagrees with the CC's argument. The CC's approach focuses only on local market dynamics and fails to recognise how hospital groups use these 'hospitals of concern' in negotiations with insurers. BHF believes that a divestment of a Single hospital that is part of a large group portfolio would improve an insurer's buyer power against a hospital group that has had such a key facility divested. In addition, the insurer would also be able to negotiate better terms with the Single hospital itself as the risks of going out-of-contract would be constrained to a smaller market.

3.10 If the CC is convinced that divestments in Single / Duopoly markets are not appropriate, it must give full consideration to alternative remedies to address the AEC identified in these markets, including a fuller consideration of a 'price control' remedy.

Impact of divestments on insurer bargaining power

3.11 BHF believes that the CC's proposed remedy is unlikely to rebalance materially the bargaining position between the large hospital groups and insurers (in particular smaller insurers).

Spire, Ramsay, and Nuffield

3.12 Spire, Ramsay, and Nuffield portfolios will not see any divestments. Spire and Nuffield will still have ✂ of their revenues from BHF in Single or Duopoly markets (we assume that the position for other insurers will be similar)[35]. Further, the CC has not restricted these hospital groups from being suitable acquirers of divested hospitals from BMI and HCA. As a result, these operators could, subject to purchaser approval from the CC, increase their size and strengthen their bargaining position, which would be entirely counterproductive.

BMI

3.13 The CC has proposed seven areas in which BMI must divest a hospital, and in five of these areas it is giving BMI discretion over which of two possible hospitals it may wish to divest. BHF agrees that divestments in these areas should improve local competition and benefit self-pay patients in particular. However, BHF believes that the divestment of a larger facility is likely to have a more significant impact on local competition:

i. The CC's price concentration analysis estimates that "*self-pay prices decline by between 3 and 4 per cent for every 20 percentage point reduction in weighted average local market share*"[36]. The CC uses this analysis to reason that "*divestitures which reduce local market shares should have a direct effect on the prices charged to self-pay patients*"[37].

ii. The divestment of a larger facility (in areas where BMI has discretion over which of two possible hospitals it may wish to divest) will reduce local market share by a greater amount. Hence, BHF believes that it is not unreasonable to expect that the divestment of a larger facility is likely to have a larger impact on local competition and further decrease self-pay prices.

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[34] PDR, paragraph 2.63
[35] Ramsay, despite being a much smaller hospital group with significantly fewer Single or Duopoly hospitals, has earned excessive profits in three of the five years looked at by the CC. This illustrates the significant market power the other main groups hold. ✂
[36] PDR, paragraph 2.68
[37] PDR, paragraph 2.68

3.14 While divestments are likely to improve local competition, BHF remains concerned that the BMI divestments will not be sufficient to drive prices down for insured patients to competitive levels. Though the divestments will impact the BMI portfolio, they will not be enough to rebalance insurers' bargaining power against BMI:

i. Prior to the divestments, approximately ✂of BHF's annual claims expenditure with BMI was at hospitals in Single or Duopoly markets, markets in which BHF has little effective choice.

ii. If we assume, as we believe is likely, that in each case in which BMI has discretion over which facility it divests it chooses the smaller of the two in that cluster, BMI will have to divest only ✂ Single hospital, leaving it with ✂ Single hospitals and ✂ Duopoly hospitals. ✂ [38]. Indeed, BMI could even grow in scale and market power if it is allowed to buy HCA's divested facilities in central London. While the remedies are expected to reduce BMI's local market power in the divestiture areas, it is unlikely that they will improve insurer bargaining power significantly, especially for smaller insurers. It is very uncertain that this impact will be sufficient to bring BMI pricing down towards competitive levels.

iii. ✂

3.15 BHF believes the CC can strengthen its remedy package in relation to BMI by specifying (rather than leaving to BMI's discretion) that BMI divest the largest facility in each of the five clusters[39]. As explained above, this should increase local competition and benefit self-pay patients by a greater extent than the divestment of a smaller facility. In addition, a larger hospital is more likely to offer a broader range of specialisms, benefit from economies of scale, and benefit from a more established reputation in the local area. These factors are likely to attract a greater number of buyers for divestment. Moreover, the scale of a larger hospital is likely to have a greater impact on hospital group market power – BHF has outlined previously (in Section 2 of this response and in a separate submission to the CC dated 6 December 2013) how scale of large hospital groups drives group market power in national negotiations with insurers.

HCA

3.16 Central London is the most important cluster market. It is an absolutely critical market to private healthcare in the UK because of its size and its importance to corporate customers of PMI.

3.17 In its PFs, the CC found clear evidence of HCA's strength in the central London market: "*HCA has high shares of supply relative to its competitors. HCA has a share of supply in central London above 45 per cent by admissions (inpatient and inpatient plus day-patient) and above 55 per cent by revenue (patient and total).*"[40] In particular, the CC found that HCA has a share by admissions of over 40 percent in 11 of 17 specialties. Figure 5 of BHF's response to the Remedies Notice highlighted the dominant position HCA held within BHF's central London spend across a number of key specialisms ✂. In particular, HCA has a market share of✂ in each of the top 9 specialisms (these 9 specialisms account for ✂of BHF's spend with HCA in central London). HCA also enjoyed significant and sustained excess profitability.

[38] This is because most of the divested facilities are likely to be in a cluster market and as a result BHF's expenditure with BMI at Single and Duopoly facilities will decrease by a smaller proportion relative to the total decrease in BHF expenditure at all BMI facilities. For example, if in each case in which BMI has discretion over which facility it divests it chooses the smaller of the two in that cluster, the combined impact of the seven hospital divestments will be a reduction of BMI's total scale by only around ✂ (in BHF revenue terms). In comparison, BHF's expenditure with BMI at Single and Duopoly facilities will ✂

[39] BHF response to CC's Divestment Options Paper, paragraph 2.12 and pages 20 to 31

[40] PFs, paragraph 6.125

3.18 The evidence underpins a clear need for divestments in central London. In the PDR, the CC has proposed that HCA divests: The London Bridge Hospital and The Princess Grace Hospital. BHF strongly welcomes the need for divestments of multiple HCA facilities; a divestment of only one facility would be inappropriate and ineffective. Introducing two (or more) new players into the central London market would improve insurers' choice and encourage greater competition on price and quality.

3.19 However, BHF is concerned that the divestments of Princess Grace and The London Bridge do not go far enough to rebalance bargaining power, as HCA will remain in a strong position:

i. The divestment of the London Bridge Hospital and the Princess Grace Hospital would still leave almost ✂of BHF's claims expenditure in central London at HCA[41].

ii. HCA will remain dominant (with a share of over 40% by revenue) within central London in ✂. In particular, HCA would still account for more than ✂ of BHF's claims expenditure in the following specialisms: ✂ . Therefore, while the divestments improve the bargaining position of insurers, they do not neutralise HCA's significant market power held in particular specialisms. BHF is strongly of the view that divestments must be targeted at improving competition at the specialism level, not just at an aggregate share level. HCA derives its strength from its dominance of key specialisms.

iii. ✂

iv. HCA is already expanding its position in central London to reinforce its market power. HCA recently announced plans to open a private clinic across three floors of the Shard tower near London Bridge[42].

3.20 BHF strongly agrees with the CC that the divestment of The London Bridge must be part of any divestment package. However, we believe that divesting the Wellington hospital rather than the Princess Grace is likely to be more effective in improving competition in central London at the specialism level. If The London Bridge and Wellington were divested, each to separate buyers, HCA's aggregated market share would decrease to approximately ✂.

3.21 In addition, BHF is concerned that the CC has not proposed the divestment of HCA's interest in the Roodlane practice. This practice (acquired by HCA in 2011) provides an important channel into the London Bridge Hospital. We are concerned that if HCA retains its interest in the Roodlane, it could easily redirect patients away from the new owners of the London Bridge Hospital (to for example the new Shard facility). The CC should reconsider separating the ownership of Roodlane from HCA post-divestment as it will ensure that patient referrals to the London Bridge Hospital do not get affected.

Suitable acquirers

3.22 BHF welcomes the condition the CC places that any acquirer must have suitable expertise. However, BHF believes that the CC must be clear in specifying which operators are NOT suitable acquirers[43].

i. BHF would have <u>significant concerns</u> if the purchaser of a divested facility is one of the other existing large hospital groups (BMI, HCA, Nuffield, Ramsay, Spire). Acquisition by these groups will only expand their scale and potentially increase the

[41] See BHF's Response to the Remedies Notice, paragraphs 4.84 to 4.93.
[42] See footnote 10
[43] BHF response to CC's Divestment Options Paper, paragraph 2.16 and 2.17

number of 'must have' hospitals under their portfolios – this could be entirely counterproductive in relation to rebalancing bargaining power between insurers and these groups.

ii. The London Clinic should not be allowed to purchase any divested HCA facilities – this would prevent the creation of a new operator with major strength in central London.

iii. BHF agrees with the CC that "*where the CC specifies the divestiture of two or more hospitals in a local area, our [the CC's] preference will be for the facilities to be sold to different purchasers unless there is a compelling competition reason for permitting a single purchaser to acquire both/all the facilities.*"[44] In particular, BHF notes that a single acquirer should not be able to buy two (or more) of the divested HCA facilities. BHF raises similar concerns regarding the divestment of BMI's facilities. ✂

iv. If another insurer were to acquire a 'must have' hospital, then steps must be undertaken to ensure other insurers would continue to have access to that facility on fair and reasonable terms.

3.23 The CC will require insurers to continue recognising the divested facilities for a period of 18 months on the same contractual terms as pre-divestment, whilst permitting a shorter period by mutual agreement. While BHF agrees that divested facilities should continue to be recognised by insurers to prevent disruption to patients, we do not believe this recognition should necessarily be on the same terms and conditions as pre-divestment. We believe that insurers must at least be given the option (but not the obligation) to renegotiate existing contracts with both the new owner of a divested facility and the main hospital groups that have divested facilities. There must be an opportunity to rebalance prices and maximise consumer benefits as quickly as possible following divestments.

Conclusion

3.24 To be effective, any divestments must be part of a wider remedies package, as explained in paragraph 2.19 of our response to the CC's Divestment Options Paper. For example, a ban on consultant incentives should take immediate effect for the divesting group to avoid it poaching all the key consultants and staff from the divested hospital.

3.25 However, BHF does not believe the divestments proposed by the CC are sufficiently effective to address the AECs or customer detriment. They do not rebalance bargaining position between the main hospital groups and insurers.

3.26 As noted above, the CC is required to have regard to the need to achieve as comprehensive a solution to an AEC as is reasonable and practicable. The CC must therefore give full consideration to possible remedies to address the weak competitive constraints it has identified in many local markets, including Single and Duopoly markets – these weak constraints are a feature of the PH market that give rise to an AEC. It is not clear from the PDR that the CC has in fact discharged its duty to consider fully a comprehensive solution to the AEC. In particular, it is not evident that the CC has given sufficient consideration to remedies intended to address the weak competitive constraints in Single and Duopoly markets.

3.27 On this basis, BHF believes that further remedies must be considered more fully; in particular further divestment remedies. As outlined in previous submissions[45], we believe the following

[44] PDR, paragraph 2.85
[45] Paragraphs 4.52 and 4.53 of BHF's response to the Remedies Notice and paragraph 1.6 of BHF's response to the Divestment Options Paper

package would be proportionate and significantly more likely to be effective in addressing the AEC in Single and Duopoly markets than the CC's current proposal:

i. **A price control of the approximately ✂ hospitals in Single markets** – the most effective way to constrain the risk for both self-pay patients and insurers in hospitals of concern unaffected by the cluster divestment remedies would be a price control regime. Currently, no other remedy addresses the consumer detriment in Single markets. The CC has not quantified the costs involved and the potential benefits that could arise from a price control regime. BHF considers the costs involved are likely to be small in comparison to the benefits realised by self-pay patients (from lower prices) and all insured customers from an improved bargaining position against the hospital groups.

ii. **Divestment of certain Asymmetric duopoly facilities by the large groups** – such divestments would improve insurers' bargaining position against the standalone facility and the main hospital group, which would now own fewer hospitals of concern. If there is a price control on Single hospitals, BHF proposes that divestment of Asymmetric duopoly hospitals can be targeted at the following short list of facilities ✂

    a) ✂

    b) ✂

    If no price control was to take place, then in addition to the package of Asymmetric duopolies above, BHF also proposes the divestment of the following Single hospitals ✂.

    a) ✂

    b) ✂

    c) ✂

4. MARKET OPENING REMEDY

REMEDY 3: RESTRICTIONS ON EXPANSION

4.1 The CC has provisionally found that because PPUs are generally co-located with NHS facilities and benefit from their infrastructure and support facilities, partnering with a PPU may offer a lower-risk means of market entry for private hospital operators. However, if an existing hospital operator in that local market entered into a partnership or business agreement with the NHS Trust to manage the PPU, this would prevent a new entrant from doing so and thereby prevent market concentration being reduced. The CC therefore proposes a 'market opening' remedy that would make it easier for a new entrant to partner with an NHS Trust to operate a PPU[46].

4.2 The PDR sets out a modified form of this remedy comprising the elements:

i. The remedy will apply to all private hospital operators across the UK (including central London);

ii. Any private hospital operator and NHS Trust entering into a management arrangement in relation to a PPU must pre-notify the arrangement to the OFT/CMA for approval[47];

iii. All PPU management arrangements must be pre-notified. Mandatory pre-notification applies also to those PPU transactions that qualify as a 'relevant merger situation' within the merger regime[48];

iv. In assessing the effect of an arrangement, the OFT/CMA will apply 'a competition test' equivalent to the Substantial Lessening of Competition ("SLC") test used in merger control. A case-by-case analysis will be undertaken in which both the harm to competition and, if harm is found, the relevant customer benefits of the arrangement will be assessed and weighed. The competition test will not be a simple 'bright line' test based on hospital fascia count in the affected local market;

v. On the basis of the competition test, the OFT/CMA will decide whether the arrangement should be approved, undertakings given by the parties as a condition of approval, or prohibited;

vi. For transactions that do not otherwise fall within the merger control thresholds it will be a one-phase process[49]. The OFT/CMA will not have the option to refer the matter on for second phase review; and

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[46] PDR, paragraphs 2.178 and 2.179.
[47] The OFT/CMA will monitor public information sources to identify proactively any PPU management arrangements which fail to be notified. Monitor will alert the OFT/CMA of any arrangements that it becomes aware of through its assessment of Foundation Trust forward plans.
[48] PDR, paragraph 2.258.
[49] The CC should further clarify how PPU arrangements that qualify as relevant merger situations under the normal mergers regime fit within this approach. Paragraph 2.248 (of PDR) suggests that a decision on PPU arrangements would be taken "*in all cases*" without a stage 2 reference. However, this would be odd if the arrangement could otherwise be referred to stage 2 in the merger regime for thorough review. For these qualifying merger arrangements, it would be perverse for the competition test to force an earlier, less detailed decision from the OFT/CMA, where the option of CC review was available.

vii. 'Safe harbour' provisions are being considered by the CC[50]. These may allow an arrangement to avoid further scrutiny if it could be shown that the arrangement (i) would not give rise to an increase in the private hospital operator's share of supply in the relevant area to more than 25 per cent; or, (ii) fell beneath a *de minimis* threshold in value (the level of which is as yet unspecified).

4.3 BHF welcomes the proposed remedy. We agree that it is necessary and should be put in place immediately following the inquiry. However, BHF has a number of points of concern about its design, implementation and impact.

A move away from outright prohibition

4.4 The proposed remedy significantly amends the proposal set out for consultation by the CC in its Remedies Notice. At that point, the CC had suggested an outright prohibition on private hospital operators in Single or Duopoly markets partnering with local PPUs. The PDR explains that the CC considers the amended proposal to be more flexible. It claims that conditions of competition in Single/Duopoly markets will change over time and that some arrangements between a PPU and a local incumbent private hospital may have relevant customer benefits. BHF has not seen any analysis of this claimed benefit to consumers. Moreover we note that in softening the stance on outright prohibition, there is the risk that certain anticompetitive arrangements may not be covered. In order to prevent this and to ensure the effectiveness of the remedy, the OFT/CMA must be given sufficient time and resources to conduct robust analysis of all relevant arrangements.

Scope

4.5 BHF agrees that this remedy must cover all private hospital operators, any PPU management arrangements (irrespective of structuring), and the whole of the UK (including central London). The remedy must not be restricted in its scope[51].

The competition test

4.6 Further clarity must be given by the CC on how the competition test will work:

- *Specification of test*: Paragraph 2.247 of the PDR says that the competition test would be "*the equivalent*" of the SLC test, where paragraph 2.248 says "*While the competition test would resemble the SLC test, there would be differences in its application*". More explanation on these differences would be welcome.

- *Level of proof*: For many PPU arrangements, the OFT/CMA will be the final decision maker (with no onward referral to the CC)[52]. A higher level of confidence will therefore be required than may be typical in normal first phase merger assessments. This will require a deep level of analysis.

[50] PDR, paragraph 2.250.
[51] The PDR explains that some hospital operators argued that the remedy should not apply to them because the CC did not find the operator to have market power against insurers in the PFs. BHF disagrees. Some of the hospitals within an operator's portfolio may have market power at a local level (against both insurers and self-pay patients), and the operator should be restricted from further expanding its presence in that local market through partnering with the local PPU. Further market conditions may change over time, meaning that limiting this remedy to only BMI, HCA and Spire would no longer be appropriate in future.
[52] We assume that PPU arrangements that qualify as relevant merger situations within the merger regime will be treated within that regime.

- *Depth of analysis*: BHF strongly agrees with the CC that a simple hospital fascia count analysis is inappropriate (in particular in central London). The OFT/CMA's analysis must establish: (i) the dynamics of competition in the local market at the specialism level[53]; (ii) the effects on different stakeholder groups (insurers, self-pay, etc.); and (iii) that any alleged benefits are real, quantifiable and will pass through to consumers. Interested parties must be given opportunity to comment on the analysis and, where necessary, input further evidence. Therefore, BHF believes an in depth and rigorous analysis is required (rather than any "bright-lines" approach).

- *Relevant customer benefits*: Any alleged benefits from the partnership between a local incumbent and the PPU must be proved to a high standard if they are to outweigh and rebut the clear reduction in local competition. In particular, the OFT/CMA should be obliged to involve Monitor in assessing the benefits case advanced by the parties (particularly where alleged benefits are clinical in nature). Critically, the hospital operator must show that the benefits are unique/specific to its proposed partnership with the PPU. If the benefits are achievable through a partnership with another private operator, which caused less negative impact on competition, then they cannot be counted. A higher transaction price received by the NHS Trust should not be counted as a relevant customer benefit. The incumbent may choose to outbid others precisely because this will protect its existing market power.

- *Time period for review*: The CC has not set a time limit for the OFT/CMA to review and decide on a proposed arrangement between a hospital operator and a PPU. We assume that if an arrangement qualifies as a relevant merger situation, the normal timetables for mergers should apply (with the possibility of a second-phase review if required). Where the arrangement is not a relevant merger situation, the time available for review must allow for detailed assessment of the evidence, an opportunity for public consultation, and sufficient time to design, and consult on, any undertakings from the parties as conditions of approval. As the OFT/CMA will be reaching a 'final' decision in these cases (without the possibility of referral for a second-phase review), the timetable allowed should be sufficiently long and flexible to allow for full analysis of the facts. This period may need to be longer than the statutory 40 working days allowed in a standard first phase merger review.

Safe harbours

4.7 BHF strongly disagrees that safe harbour provisions should be included in the remedy. These will undermine the effectiveness of the remedy and could lead to unintended consequences.

4.8 NHS Trusts often seek a private partner at a point where the PPU is still nascent (in the planning/set up phase when activity and value is very low). Safe harbour provisions would allow, and motivate, a local private hospital incumbent to tie itself to the local PPU while the PPU is still in this nascent state (when transaction value or an increase of share of supply may appear minimal). The market may remain concentrated, and entry foreclosed, simply because the incumbent acted quickly to nip competition in the bud while still within the safe harbour.

4.9 A safe harbour related to value may also be circumvented through contract structuring e.g. where one party is remunerated indirectly or in kind rather than through direct monetary payment.

[53] Examining each specialism separately is in line with CC's conclusions on market definition in the market inquiry. The OFT mergers precedent of looking at more aggregated clusters of care (e.g. inpatient, outpatient, community etc.) would not be satisfactory in capturing the full dynamics of competition in the market.

4.10 An unintended consequence of safe harbours would therefore be to encourage incumbent hospital operators to accelerate strategies to acquire PPU management arrangements, or to structure arrangements in a certain way, in order to fall within the safe harbour provisions.

Effectiveness

4.11 BHF considers that this remedy could be effective in offering some protection against concentrated markets becoming more concentrated. However, we note that it does not provide any positive impetus to address existing concentration or customer detriment. Moreover, it relies on PPUs becoming viable competitors, which is in many markets uncertain. The CC itself notes, for example, that it is unlikely that the NHSs in Scotland, Wales and Northern Ireland will open PPUs[54]. Therefore, this remedy has no positive impact for consumers outside of England.

4.12 BHF appreciates that the remedy is positive and must be viewed within the package of remedies proposed by the CC but even within this package, BHF believes that this market opening remedy makes only a small contribution to addressing the significant existing customer detriment found by the CC.

[54] PDR, paragraph 2.253.

5. CLINICIAN INCENTIVES REMEDY

Introduction

5.1 In this section, BHF comments on the CC's provisional decision on a remedy to address the AEC that the CC has provisionally identified as resulting from consultant incentive schemes (the "**Clinician Incentives Remedy**").

5.2 The CC has provisionally decided *"to ban direct incentives (subject to a £500 a year de minimis exception) and to place conditions on equity participations by doctors in either private hospitals or joint ventures involving companies which own or operate a private hospital. We recommend that the OFT/CMA should monitor and enforce compliance with this remedy by private hospitals".*[55]

5.3 Taking the specific elements of the CC's Clinician Incentives Remedy in turn, BHF sets out below its views on each of these. BHF broadly agrees with the CC's proposals in the Clinician Incentives Remedy, but it believes that:

a) The disclosure of goods or services which fall under the £500 *de minimis* threshold must be made within one month and remain publicly available for five years.

b) The CC should draw up guidelines by which hospital operators are able to assess fair market value.

c) The CC should set up a reporting system through which third parties can report potential breaches of the Clinician Incentives Remedy to the OFT / CMA.

d) BHF's position remains that equity holdings in hospitals by clinicians should be prohibited entirely for the reasons set out in our response to the Remedies Notice. However, if the CC is minded to permit these the CC should prohibit outright the offering to clinicians of equity in private hospital parent groups and subsidiaries above the hospital level, drawing on developments in the US (since such holdings could have a very significant tying effect and consequently distort referral behaviour by clinicians).

e) The CC should introduce an outright prohibition in relation to equity in equipment, since such equity holdings are more likely to have a directly disproportionate effect on referral patterns than a holding in a hospital. Equity held in equipment is not necessary to support market entry, and we see no positive reason why this should be allowed.

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[55] PDR, paragraph 2.405

f) To the extent that the Clinicians Incentives Remedy does not apply equally to GPs, the CC should take its own reasoning to its logical conclusion and introduce a similar prohibition on incentive schemes for GPs.

A ban on direct incentives

5.4 BHF fully agrees with the PDR that there should be a ban on direct incentive schemes between hospital operators and clinicians. As the CC notes in its PDR, "*we [the CC] thought that any scheme operated by a hospital operator, whether contractual or not, which provided an inducement to, or created an obligation to, a clinician to treat or refer patients for tests at its hospital or hospitals should be prohibited outright*". The CC goes on to note that such schemes "*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*".[56]

5.5 BHF agrees with the CC's position and is strongly of the view that any remedy designed to address the AEC resulting from consultant incentive schemes must include a prohibition on all incentive arrangements that affect, or which have the potential to affect, referral patterns. BHF agrees with the CC that simply amending current incentive arrangements, including by incorporating obligations in such arrangements that require the clinician to comply with GMC guidelines, would be insufficiently clear-cut and effective to address the AEC which has provisionally been identified.

A de minimis threshold of £500

5.6 BHF agrees with the CC's position that, in the interests of proportionality and workability, a £500 de minimis threshold (being the cumulative annual value of services that a hospital operator could provide to a clinician) reflects the fact that "*there was a level below which the value of any service or benefit offered or provided to a clinician would be likely to have no effect on his/her behaviour and would not therefore constitute an incentive*".[57]

5.7 BHF also agrees that, in the interests of transparency, the private hospital operator should be required to disclose publicly the services alleged to fall under this limit. BHF is of the view that this disclosure obligation should also specify a time limit for the disclosure of the information (e.g. within one month of the goods or services being provided), with the disclosure being publicly available for 5 years from the point at which the goods or services are provided.

Services of higher value offered at fair market value

5.8 The CC has proposed that, where a hospital operator provides services to a clinician, and the value of those services exceeds £500 a year, any service in excess of that £500 threshold should be:

i. Charged to clinicians at its fair market value;

[56] Paragraph 2.382, ibid.
[57] Paragraph 2.376, ibid.

ii. Available to all clinicians with practising rights at the relevant hospital (i.e. non-selective); and

iii. Disclosed on the private hospital operator's website, together with the market value ascribed to that service by the hospital.

5.9 BHF recognises a case for allowing the provision of certain services to clinicians by hospital operators at fair market value. BHF agrees that any such services should be disclosed publicly along with the relevant fair market value. However, it is not clear how the CC anticipates fair market value being calculated, and by whom.[58] In BHF's view, any assessment of fair market value should be undertaken by the relevant hospital operator according to a set of guidelines and principles designed by the CC and policed on a continual basis by the OFT / CMA.

5.10 It is also very important that services provided by clinicians to hospitals are subject to a similar level of transparency and fair market value calculation. One particular aspect of this which the CC should examine closely is whether hospitals are paying disproportionately high and uneconomic rates to consultants for NHS "choose and book" procedures in place of the direct financial inducements previously offered for private referrals. It is important that the CC ensures that its remedies are not easily circumvented in this way.

5.11 BHF notes that interested parties will be able to challenge the fair market value ascribed to particular services by hospital operators and that the OFT/CMA will be responsible for policing compliance with this element of the Clinician Incentives Remedy.[59] While BHF welcomes the ability to challenge fair market value and the oversight provided by the OFT / CMA, BHF would propose that a more active 'whistleblowing' or reporting system is considered by the CC, in order to allow and encourage clinicians and other parties to report alleged breaches of the Clinician Incentives Remedy to the OFT / CMA. For example, the CC could consider as part of the remedy the setting up of a dedicated email address and hotline at the OFT / CMA to which clinicians or other third parties could report suspected breaches. These contact details should be published on hospital websites alongside the details of any services provided to clinicians at fair market value. BHF notes that, in this regard, the CC envisages the OFT / CMA notifying the GMC in the event of incentives which are in breach of the Clinician Incentives Remedy or which it considers may be incompatible with the GMC's guidelines – a reporting mechanism as proposed by BHF would facilitate this process.

5.12 BHF would also welcome clarification that this element of the Clinician's Incentive Remedy applies equally to goods, in addition to services.

Equity participation schemes

5.13 The CC has provisionally decided that "*equity participation schemes between private hospital operators and clinicians practising at or referring patients to the hospitals concerned should be allowed*".[60] The Clinician Incentives Remedy does not cover schemes "*which clinicians set up*

[58] BHF notes that in relation to a consideration of equity participation schemes, the CC recognises the problem of establishing a fair market value (see footnote 169 to paragraph 2.391(a) of the PDR)
[59] Paragraph 2.292, ibid.
[60] Paragraph 2.391, ibid.

among themselves with no private hospital operator involvement" and therefore only applies to equity arrangements between hospital operators and clinicians (including schemes relating to equity held in clinics and equipment).[61] The CC's proposed exemption in respect of such schemes is subject to the following conditions:

i. The equity stake must be paid for by the clinician up front and at fair market value (the funding of the purchases cannot be provided by the hospital operator, nor can payment be deferred);

ii. Where a company that owns, directly or indirectly, one or more hospitals is involved in an equity participation scheme, the equity stake of any individual clinician with practising rights at the relevant hospital is limited to 3%; and

iii. The acquisition of an equity stake must not be linked to any express or implied requirement on the clinician to refer patients to the private hospital, to conduct a minimum percentage of work at that hospital, to practise at that hospital for a minimum period, or to commit to providing a minimum level of throughput in the case of equipment.[62]

5.14 The CC has provisionally decided that all equity participation schemes not meeting the conditions described above should be unwound, or suitably amended so as to fall within the proposed exemption, within six months from the date of the CC's final order.[63] The CC has further proposed that private hospital operators be required to disclose publicly on their website which clinicians practising at their hospitals own equity in their facilities (or in equipment within those facilities).[64]

5.15 BHF's view is that the most clear-cut and effective means of addressing the AEC in relation to clinician incentive schemes is to prohibit all equity participation schemes outright, in particular in light of recent experience and developments in the US (as to which, see below). This would also be most consistent with the GMC's guidelines and would give patients the greatest reassurance that clinicians did not face a conflict of interest. In this context, any exemptions must clear a very high threshold and should demonstrably not affect the patient's best interests. In relation to the CC's specific proposals, BHF sets out its comments on these below.

5.16 BHF notes that the experience in other jurisdictions, most notably the US, has been that there is a need to restrict equity holdings in both hospital facilities and equipment.

5.17 In particular, the Stark Law has been progressively amended, since its introduction, in order to circumscribe in an increasingly restrictive manner the use of equity participation schemes by clinicians and hospitals, as well as other healthcare providers. Under the original incarnation of the Stark Law, clinicians were prohibited only from referring patients for clinical laboratory services in which the referring clinician had an equity stake (or other financial relationship). However, following various academic studies and the intervention of the American Medical

[61] Paragraph 2.390, ibid.
[62] Paragraph 2.391, ibid.
[63] Ibid.
[64] Paragraph 2.392, ibid.

Council (which noted the distortive effects of equity stakes on clinician referral patterns), this prohibition was very significantly widened to prohibit clinicians from referring patients for various treatments or services at a range of medical facilities.

5.18 One of the newly prohibited types of services was 'inpatient and outpatient services' – so, in effect, clinicians were prevented from referring patients for in- or outpatient services at facilities in which the clinician held equity.[65] However, this prohibition was subject to the so-called 'whole hospital' exception, under which clinicians were able to refer patients to such facilities provided that the clinician held equity in the whole hospital rather than the specific facility within it. The rationale behind this exception (as also articulated by the CC in its consideration of the Clinician Incentives Remedy) was that since hospitals are large, multi-function entities, the likely benefit to the referring physician of referring patients to that hospital would be minimal.[66]

5.19 However, the Patient Protection and Affordable Care Act 2010 (better known as Obamacare) greatly restricts the use of the 'whole hospital' exception. Specifically, clinicians are no longer able to take equity in new hospitals, and existing hospitals are now not able to increase unilaterally the proportion of equity held by clinicians in them beyond the levels held as at December 2010.[67] In a challenge to the legitimacy under US law of the narrowing of the 'whole hospital' exemption, the Secretary for the United States Department of Health and Human Services noted four primary justifications for the restriction:

a) Physician ownership of facilities leads to over-utilisation of services offered at those facilities;

b) Physician ownership results in greater healthcare expenditures;

c) Referral patterns undermine public and community hospitals, which provide uncompensated care and other services not offered by physician-owned hospitals; and

d) Physician-owned hospitals provide inadequate emergency care.[68]

5.20 While some of these justifications are clearly unique to the US context, it is notable that the first justification is that facilities in which physicians hold equity have a tendency to overtreatment or otherwise to over-utilise services – which logically leads to the second justification, namely that such facilities have greater expenditure. The US experience therefore suggests that regulators increasingly believe that the ability of clinicians to hold equity in hospitals and other facilities, as well as equipment, is problematic. In this light, BHF's view is that the disadvantages to the patient of such schemes clearly outweigh any potential advantages.

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[65] Equipment of various kinds was also included in the new range of facilities / services in which the holding of equity was prohibited.

[66] There were also fact-specific reasons for including this exemption, primarily that many rural hospitals in the US operated on the basis of physicians holding equity in them – banning such holdings outright would therefore have had a disproportionate effect on the provision of healthcare in these localities.

[67] This development is also noted at Appendix 2.7 of the PDR

[68] See Physician Hospitals of Americ a and Texas Spine & Joint Hospital, Ltd vs Secretary for the US State Department of Health and Human Services, in particular p.15, available at http://www.justice.gov/healthcare/docs/physicians-hospital-03312011.pdf

5.21 Based on the real-life experience of the US we believe that clinicians holding any equity stake in a hospital should not be allowed to refer to that hospital. This is the only arrangement which is truly consistent with GMC guidance on good medical practice. We believe that real-life experience in the US outweighs any theoretical benefits that have been ascribed to clinicians owning equity in the hospitals to which they refer.

5.22 Furthermore, we believe that if the CC keeps this loophole open we will see a proliferation of such schemes, and the development of mechanisms to effectively circumvent the conditions imposed by the CC.

Application of the equity participation scheme exemption to equipment

5.23 The CC has provisionally decided that equity stakes in equipment should not be prohibited, but should be subject to the conditions in paragraph 5.13 above.[69] BHF does not believe that such an exemption is justified or appropriate. While the dividends / rewards available to a clinician through an equity holding in a particular piece of equipment are likely to be lower in absolute terms where such a holding is limited to 3% of the total equity, it is nevertheless clear that such holdings are likely to have a disproportionate effect on referral decisions. In particular, referring only a few patients for treatment using a single piece of equipment is likely to have an immediate effect on the value of the equity holding, whereas referring the same number of patients for treatment at a particular hospital facility in which equity is held is likely to have a far more diluted effect (given the likely myriad types of treatments, tests and operations happening at that facility at any given time). Clinicians may therefore be biased in favour of referring patients for treatment which uses a particular piece of equipment in which they hold equity. Against this, there is no reason to believe that the ownership of equity stakes in equipment is required to enable market access or any other benefit to the consumer.

5.24 For this reason, BHF is concerned that equity stakes in equipment carry with them the risk that, even if restricted to a 3% holding, clinicians will be incentivised to refer patients to treatment which uses that particular equipment. In some cases this has the potential to lead to patient harm, for example over-exposure to radiation or false-positive tests which lead to unnecessary treatment. BHF would therefore propose an outright prohibition on clinicians holding equity stakes in equipment. Moreover, BHF's view is that this prohibition should also apply to other types of ownership structure in equipment as anything less than this is a clear departure from the spirit of the GMC's guidance and the professional expectations and standards which should be required of clinicians.

3% cap

5.25 BHF's understanding is that the purpose of the 3% cap on equity holdings is to restrict the clinician's right to revenues from facilities or equipment in which they hold equity, in order that referral patterns or other referral behaviour are not materially prejudiced by the receipt of those revenues. For such a cap to be effective it is essential that the CC requires that the proposed 3% cap on the level of equity that can be held in a facility also applies to the level of profits /

[69] See also paragraph 2.391, ibid.

dividends to which the clinician equity-holder is entitled as a result of that holding – such that any profits / dividends can only be distributed to clinicians on a strictly pro-rata basis.

5.26 BHF also believes that significant referral incentives could arise where hospital operators offer clinicians equity in the hospital group parent company or subsidiaries above the level of the individual hospital (rather in subsidiary companies comprising individual hospitals, or in equipment). In such cases, a cap of 3% on such equity would not be sufficient to mitigate against the incentives that such a holding would likely exert (given the very substantial market capitalisation of certain hospital operators). For this reason, BHF's view is that the most clear-cut and effective solution is for equity holdings in hospital parent companies and subsidiaries above the individual hospital level to be prohibited outright. This would have the advantage of being in line with the spirit of GMC guidance and as such consistent with reasonable professional expectations of clinicians[70].

Application of Clinician Incentives Remedy to GPs

5.27 BHF believes that any remedy looking to address the AEC identified in relation to incentive schemes must logically extend to incentive schemes between hospital operators and GPs (in particular given the lack of proposed action by the CC on vertical integration by hospital operators).

5.28 The CC does not expressly mention either consultants or GPs in its 'Conclusions on Remedy 4' (i.e. the Clinician Incentives Remedy), merely noting that the CC proposes to ban "*direct incentives…and to place conditions on equity participations by doctors*".[71] However, based on the CC's own analysis BHF believes that the CC must require the Clinician Incentives Remedy to cover both consultants and GPs and that this needs to be stated more clearly. The following extracts clearly demonstrate the relevance of the CC's own analysis to GPs:

i. In the PDR, the CC expressly notes that its consideration of direct incentive schemes covers "*doctors (whether consultants or GPs)*", before going on to conclude provisionally that any incentive scheme which directly induces or creates an obligation on a "*clinician*" to refer patients to a particular facility should be banned outright.[72] Given the role played by GPs in referrals, such a prohibition necessarily also extends to incentive schemes between GPs and hospital operators.

ii. Likewise, it appears that the element of the Clinician Incentives Remedy dealing with equity participation schemes should also be read as applying equally to GPs (since it reads "*equity participation schemes between private hospital operators and clinicians practising at or referring patients to the hospitals concerned should be allowed*" subject to the relevant conditions). However, BHF notes that the submissions relating to equity participation schemes made to the CC and cited in the PDR are restricted to

[70] See in particular paragraphs 77-80 of the GMC's Good Medical Practice guidelines.
[71] Paragraph 2.405, ibid.
[72] Paragraph 2.381 – 2.382, ibid.

consultants (and do not take a clear enough position in relation to equity participation schemes in which GPs may be involved).[73]

5.29 Should the Clinician Incentives Remedy (or any element of it) not apply to incentive schemes entered into between, or offered by, hospital operators to GPs (including equity participation schemes), BHF would note that this would be inconsistent with the CC's stated intention behind the remedy:

a) The CC's identification of an AEC arising out of the use of incentive schemes by private hospital operators is not expressly restricted to the use of such schemes in relation to consultants alone. Any remedy looking to address this AEC should therefore logically cover incentive schemes aimed at, or involving, both consultants and GPs. Indeed, from a patient's perspective, the GP referral is a particularly important part of their treatment journey and, given the existing relationship between the patient and the GP, it is even more important that no possible conflict of interest should arise.

b) The CC expressly notes in the PDR that "*in general, any arrangement by which the economic benefit to the adviser varies according to the advice given has the potential to distort competition between hospitals for referrals*".[74] Clearly there is no reason why this statement should be limited to incentive schemes involving consultants and should, in BHF's view, be read as extending to incentive schemes involving GPs.

c) Various respondents (including hospital operators) cited in the PFs raise specific concerns about the anti-competitive effects of incentive schemes involving GPs. For example:

i. Spire states that: "*it does not believe that it is appropriate for hospital operators or insurers to offer GPs incentives in return for referring patients to a particular private hospital or alternative healthcare provider*".[75]

ii. Ramsay "*did not agree with offering direct financial incentives to GPs or other providers of primary care*".[76]

iii. The BMA notes that "*GP referrals should be based on clinical decisions, not financial incentives, and that GP incentives raised ethical issues and would be contrary to GMC guidance*".[77]

A wide range of interested parties (including hospital operators) therefore appear to disagree with incentive schemes offered to GPs.

d) The CC's survey of healthcare professionals (covering both GPs and consultants) found that 22% of the respondent GPs' referrals "*named the hospital but not the*

[73] See paragraphs 2.384 – 2.387, ibid.
[74] PDR, paragraph 2.278.
[75] PFs, paragraph 8.99.
[76] Paragraph 8.65, ibid.
[77] Paragraph 8.113, ibid,

consultant", and this figure rises to 28% in respect of London-based GPs.[78] This suggests that a material channel of referrals to hospitals is in the hands of GPs – hospital operators may very well attempt to control or at least influence this channel through the offering of, or entering into, incentive schemes with GPs. BHF believes that any such schemes would clearly influence referral patterns and should therefore (as with consultant incentive schemes) be prohibited.

5.30 For the reasons given above, BHF therefore believes that any remedy looking to address the AEC identified in relation to incentive schemes must logically extend to incentive schemes between hospital operators and GPs (in particular given the lack of proposed action by the CC on vertical integration by hospital operators).

5.31 BHF would welcome greater clarity from the CC on this point.

5.32 In relation to the CMA's enforcement options with regards to the Clinician Incentives Remedy, our understanding is that enforcement is available to the CMA in the courts (by way of injunction or other appropriate relief). Moreover, individuals (including insurers) suffering loss or damage as a result of a failure to comply with the Clinician Incentives Remedy have the right to bring an action for the recovery of that loss or damage in the courts. Bupa would welcome an express reference to the CMA's enforcement powers and the rights of individuals affected by a breach of the Clinician Incentives Remedy. We note that, notwithstanding the possibility for private actions, in practice it will be critically important that the CMA continues to be engaged with this remedy, and is willing to take speedy action in the event that there is evidence of a breach. It will also be important that there is a clearly signed route for private parties, who will not always be in a position to bring or to fund an action themselves, to complain to the CMA and provide evidence of any breach of the undertakings by hospitals and consultants. BHF also notes in this context that the CC envisages that the OFT / CMA will notify the GMC of any incentives which are in breach of the Clinician Incentives Remedy or which are incompatible with the GMC's guidelines.[79]

[78] Slide 23 of the Survey of GPs and Consultants – November/December 2012.
[79] PDR, paragraph 2.394.

6. INFORMATION REMEDIES

6.1 In this section, BHF comments on the package of remedies the CC has proposed to address the two AECs arising from the lack of information available on consultant and hospital quality and price. The package would establish an information organisation to collect and publish a specified set of information on the performance of private hospitals and consultants. The CC will also require all private consultants to provide fee information to patients, in writing, in advance of treatment.

6.2 BHF welcomes this package. It provides the necessary steps that must be undertaken by the industry to improve the architecture of information available in the sector and enable better decision making. We agree with the CC that the information remedies "*may take longer [than 2 to 3 years] to affect patient and GP behaviour, as they become familiar with them over time*"; however, establishing this platform for the industry is essential, beneficial to customers, and would not be created in the absence of CC mandate. We welcome also the recommendation that CMA review the progress of this remedy five years after its implementation.

REMEDY 5 AND 7

6.3 The CC proposed two remedies in its Remedies Notice to address the lack of quality data on consultants and hospitals. "Remedy 5" proposed a recommendation to the health departments in Scotland, Wales and Northern Ireland to collect and publish consultant performance data, as is done by NHS England. "Remedy 7" proposed that all private acute hospitals in the UK collect HES equivalent and PROMs data for private patients, with appropriate arrangements made for publication.

6.4 Following consultation the CC has concluded that the original Remedy 5 was neither effective nor sufficient in terms of helping patient to make better decisions about consultants; a position BHF agrees with. Therefore, in the PDR the CC has proposed an amended remedy that would create a data source covering both hospital and consultant performance. The PDR has combined the two remedies (Remedy 5 and 7) and modified the remedy as shown below.

"*2.465 We will require all private hospital operators with UK turnover of £5 million or more to collect and submit patient episode data for all patients treated at its facilities, whether inpatient, day-case or outpatient, to a suitable information organization from which the latter can derive the following types of performance measures at both the hospital and consultant level:*

(a) volumes of procedures undertaken;
(b) average lengths of stay;
(c) infection rates, surgical and hospital-acquired;
(d) readmission rates;
(e) revision rates (where appropriate);
(f) information on the frequency of adverse events, such as post-operative DVT and cardiac arrest (where appropriate);
(g) relevant information from clinical registries and audits as appropriate and where available;
(h) for the ten highest-volume, or otherwise most relevant, procedures, a procedure specific measure of improvement in health outcome; and
(i) a measure of patient feedback and/or satisfaction on the service provided.

2.466 In order to facilitate the analysis and publication of meaningful performance statistics, we would expect the data submitted by the private hospital operators to the information organization to:

(a) include the GMC number of the consultant responsible for each patient episode occurring in the operators' facilities;
(b) include the NHS number of patients or alternative information from which patients' NHS numbers can be derived;
(c) contain diagnostic coding for each episode in order to allow for risk-adjustment where appropriate;
(d) be fully comparable with that collected by the NHS to allow the information organization to report performance measures for the whole of consultants' practices, both NHS and private, since this is the relevant basis on which to judge performance
(e) be made available to the information organization in stages, with all the above information submitted by September 2016 to facilitate the publication of these measures over the next three years, with all data made available to the public from April 2017 onwards; and
(f) be made available with suitable data security provisions in a 'raw' format to all relevant interested parties, including the private hospital operators, consultants, insurers, the CQC, Dr Foster and HSCIC from April 2017 onwards." [80]

BHF view

This turnover threshold should not apply – all providers should be required to submit data.

BHF view

The mechanisms for funding and governance and sanctions must be specified in more detail.

BHF view

The CC should mandate all consultants to contribute to relevant clinical registries.

BHF view

It is essential that at least 10 procedures should be covered to justify the higher costs consumers face in PH when compared to the NHS.

BHF view

A standardised template should be used to collect feedback. This data should be collected independently rather than by providers themselves.

BHF view

International patients should be assigned a unique identification number.

BHF view

The CC should mandate ICD 10 diagnostic coding on a specified timetable.

BHF view

Much of the data is already collected by hospital operators – the CC should encourage first publication by early 2016.

BHF view on other items

- We disagree with the CC's view that the industry should transition away from CCSD to OPCS in the long run. The CC should instead focus the remedy on standardising the coding structure outside of CCSD (e.g. drugs, diagnostics, hospital charges) and requiring CCSD to extend its scope. The CC can also require a standardised mapping to be produced by the information organisation to aid comparability with the NHS.
- All information which is collected under these remedies needs to be made available free of charge to any party which requests it and can demonstrate the appropriate level of competence and confidentiality in handling the data.

[80] PDR, paragraphs 2.465 to 2.466

6.5 The CC explains that the "information organisation" would have the following features[81]:

i. It would be able to design meaningful performance measures in collaboration with industry participants, collect and analyse patient episode statistics and publish outcome measures in a format that is easy for patients to understand.

ii. It will be independent of the private hospital operators, insurers and consultants but able to work with these parties to ensure that meaningful information is provided to patients. The organisation would take the parties' views and legitimate interests into account when reaching decisions on what information should be collected, how it should be processed and the format in which it should be published.

iii. It would need to have an inclusive membership base, comprising the private hospital operators that submit data to it, the PMIs active in the UK market and consultant representatives.

iv. The costs of funding the organisation (estimated at £2 million per annum by the CC) would be met jointly and equally by the private hospital operators and the insurers in proportion to the number of patients they treat or represent.

v. To ensure transparency, the organisation should draw up a five-year plan setting out the information that it intends to collect, analyse and publish, together with an initial budget to support this plan. The plan would require approval from the CMA. In subsequent years, the information organisation should publish an annual report that reports a variety of items including its progress against its original plan.

vi. The organisation would need to have a strong independent management board comprising both non-executive and executive members, headed by an independent chair. The CC has suggested that two of the non-executive members of the board should be nominated by the CMA and that it may be necessary for certain issues to be reserved to these members to ensure the smooth-running of the information organisation. The CC is of the view that the Chair should nominate new board members, with the information organisation's members voting to confirm or reject the nominee.

6.6 As noted, BHF welcomes this remedies package. Below we set out some further points of clarification and consideration required in its design, implementation and effectiveness.

Scope

6.7 The CC has proposed that the remedy applies to all private hospital operators with UK turnover of £5 million or more (paragraph 2.465 of the PDR). However, this proposal omits smaller hospitals (e.g. many PPUs) and clinics. Patients receiving treatments at these facilities will be at an information disadvantage. And, of particular concern, smaller providers tend to have lower levels of activity and hence are more likely to exhibit variation in quality of care.

6.8 BHF does not see any reason as to why hospitals with UK turnover of less than £5 million cannot collect the information outlined in paragraph 2.465 of the PDR. **We strongly believe that this remedy should apply to <u>all</u> providers**.

[81] PDR, paragraphs 2.463, 2.470 – 2.475, 2.485

Information organisation

6.9 In terms of the design of the information organisation, BHF notes:

i. Representation: The CC explains that the board of the information organisation will have representation from consultants, hospitals and insurers. BHF has some concerns about how many representatives may wish to be active on the Board. BHF assumes that the top five PMI insurers and the top five private hospital operators would participate. However, independent hospital operators (e.g. Aspen and The London Clinic) and consultant bodies (e.g. Royal Colleges and FIPO) may also wish to have their own representation. More guidance is needed from the CC on the composition of the board. The CC also needs to ensure that board members (and members in general) are truly independent of each other and do not have any links which might cause them to favour one side or give the impression that they will show such favour. For example, BHF notes the very significant funding that FIPO receives from HCA and that the Private Patients' Forum is funded by the main hospital groups.

   BHF is aware of the current board structure proposed by PHIN. It is BHF's view that these proposals are clearly not workable or acceptable as they are heavily weighted towards providers and organisations in receipt of considerable funding by providers. These proposals are clearly insufficient in the outlined representation for customers and their representatives, insurers. Their representation bears too close a resemblance to the Hellenic Programme which was run according to the perceived interests of providers and so was beset by delays, inactivity and a lack of consumer driven direction.

   In our view the CC is correct to suggest that consultant representatives should come from Royal Colleges or professional bodies as independent organisations with an interest and a record of setting and maintaining professional standards. We believe that these organisations are more representative of consultants than other bodies which have been suggested and would command greater confidence across the sector.

   BHF would therefore welcome consultation by the CMA on the final proposed structure, membership and the operating plans of the information body.

ii. Non-compliance and sanction procedures: The CC's proposed remedy does not specify a mechanism through which the information organisation can sanction market participants that fail to submit data. A sanction process should be in place to ensure compliance across the industry. It would be unfair on the industry as a whole for a full CMA investigation to be launched in 5 years' time due to the reluctant progress of a few operators.

iii. CMA-nominated board members: BHF welcomes the nomination of two non-executive board members by the CMA. The CMA-nominated board members need to assist in building consensus and momentum amongst the various stakeholders. The CC asks for comment on which issues should be reserved for decision by the CMA-nominated members. BHF considers these members should have a specific role in deciding: necessary budget for the organisation; imposing sanctions on under-performing market participants; arbitrating disputes between parties; final approval of the body's plans governance and procedures and any subsequent minor changes to these, approval of membership, and providing guidance on competition law compliance queries.

Mandatory completion of clinical registries

6.10 BHF welcomes the fact that the information organisation should be able to derive relevant information from clinical registries and audits as appropriate and where available (PDR, paragraph 2.465 (g)). However, this will only be effective in driving quality improvements if all consultants contribute to clinical registries. Currently, consultant participation in registries is patchy, which undermines the effectiveness of these valuable resources. The CC's remedy should mandate that consultants must contribute to the clinical registries that are relevant to their specialisms. Further, the CC should mandate that the information in these registries is made available to insurers and other information bodies (e.g. Dr Foster).

Standardisation in information collected

6.11 Comparison between data collected by the information organisation depends critically on common methodologies being used by the hospitals/consultants collecting the information. There must, for example, be a standardised feedback form used across the industry for patient satisfaction (PDR, paragraph 2.465 (i)) and this data should be collected by a single independent organisation rather than the providers themselves. To illustrate the information that we believe this survey should include, we attach in Annex A a copy of BHF's current feedback form given to members. The feedback form should also include the option for patients to input free-form text comments about their experiences.

6.12 BHF believes a standard form should be developed by the independent organisation or the information organisation, and then mandated across the industry.

Diagnostic coding

6.13 The CC expects the data submitted to the information organisation to contain diagnostic coding for each episode in order to allow for risk-adjustment where appropriate[82].

6.14 The CC suggests that an appropriate diagnostic coding system could be ICD 10 coding (PDR, footnote 229) and even estimates the incremental cost of ICD 10 coding at approximately £4.8 million per year[83] in assessing the costs of the information remedy. However, the CC falls short of explicitly mandating the adoption of ICD 10 coding or the specific timetable of adoption. In footnote 229 of the PDR, the CC recommends that the information organisation should agree an appropriate diagnostic coding system with the private hospital operators.

6.15 BHF believes the CC should mandate all hospitals to collect information based on ICD 10 and should specify a timetable[84].

6.16 The CC also says that it expects the costs to the providers of using an ICD diagnostic code would be around £6.90 per patient. BHF does not believe these costs should be funded through the information organisation.

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[82] PDR, paragraph 2.466 (c).
[83] PDR, paragraph 2.485.
[84] We note that there appears strong consensus across a number of providers for the adoption of ICD-10. See for example: HCA response to the Remedies Notice, Section 10, Page 50; PruHealth response to the Remedies Notice, Page 17; PHIN response to the Remedies Notice, Remedy 7, Page 5; FIPO response to the Remedies Notice, paragraphs 5.5 to 5.18; AAGBI response to the Remedies Notice, Remedy 7.

Timeline

6.17 The CC says that hospitals should submit all data to the information organisation by September 2016, with all data made available to the public from April 2017 onwards. BHF does not believe that it should take this long for performance data to be made available publicly. Many hospitals already collect much of this information and we expect that they could make this information available more quickly. Therefore, we propose that the information organisation should aim to make the information available from early 2016.

6.18 The CC should also mandate the information organisation to process, analyse, and publish data received **within a specified timeframe**. Otherwise, data published will be outdated and less relevant to the patient and the rest of the industry.

Transition towards OPCS and standardisation of coding structure

6.19 BHF **disagrees strongly** with the CC's proposal to transition the industry from CCSD coding to OPCS coding by April 2019. Please see our separate paper explaining the substantial, disproportionate costs that this measure will create.

Other comments

6.20 BHF also notes the following with the CC's proposed remedy:

i. In relation to paragraph 2.465 (h) of the PDR, the CC should recommend the use of consistent measures across all private hospitals (e.g. Oxford Knee Score) to ensure true comparability.

ii. The CC should also mandate the collection and reporting of co-morbidity data as part of ICD10 reporting. This will support comparisons of health outcomes. For example, a 20 year old undergoing a knee procedure for a sporting injury is likely to have a very different health outcome compared to a 70 year old with age-related complications. Without data on co-morbidities, the information collected may be less useful since the secondary condition (or absence of it) may have a significant impact on a patient's health outcome.

iii. In relation to paragraph 2.466 (b) of the PDR, the CC recommends that the data collected should include the NHS number of patients. BHF believes that international patients, who are not registered in the NHS, should be assigned a unique identification number when they are first treated in UK's PH system.

REMEDY 6

6.21 To address the lack of information on consultant fees, the CC originally proposed (under Remedy 6 in the Remedies Notice) that consultants would be required to provide patients with a list of proposed charges for treatment in writing prior to the commencement of treatment. Remedy 6 also included a requirement for all consultants practicing privately to publish the fee for their initial consultation on the web (both on private websites and the websites of the hospitals at which they have practising privileges).

6.22 In the PDR, the CC has modified Remedy 6 as follows:

> "*2.522 Our revised proposal for the provision of information on consultant fees would take the form of an order to private hospitals to require, as a condition of granting practising privileges, that (all) consultants provide fee information to patients using standard letter templates provided by the hospital. Hospital operators would be responsible for ensuring that consultants complied with this requirement.*
>
> *2.523 At the time of confirming initial or subsequent outpatient consultation appointments, consultants should be required to provide patients with written confirmation of:*
>
> *(a) the cost of the outpatient consultation, which may be a range but, if so, should be accompanied by an explanation of the factors that will determine the actual fee level within the range;*
> *(b) details of any financial interests (shareholdings or otherwise) that the consultants in medical facilities or equipment;*
> *(c) a list of all insurers which recognize the consultants;*
> *(d) a note encouraging insured patients to check the terms of their policy with their insurer, with particular reference to the level of outpatient cover they have; and*
> *(e) the address of the information organization website, with a statement that this contains useful information on hospital and consultant quality information.*
>
> *2.524 At the time of recommending or confirming further treatment, whether surgical, medical or other, the consultant should provide patients with written confirmation of:*
>
> *(a) their diagnosis;*
> *(b) a fee quote for the specific treatment (pathway recommended for the patient. For insured patients, this should either include all consultant fees that will be charged separately from the hospital fee (surgeon, anaesthetist, radiologist etc.), or should include contact details for any specialists whose fees are not included in the quote provided. For self-pay patients, the letter should clearly state which services are included in the fee and which are excluded, such as unforeseeable complications. Where there are treatment options and the appropriate option can only be selected during surgery, these should be set out clearly with the associated fees."* [85]

6.23 BHF welcomes the modified Remedy 6. We agree that it is necessary and should be put in place, through order, as quickly as possible following the inquiry. In addition, the CC should consider for the following in the remedy's design and implementation:

i. A single standardised letter template should be used by all private hospital operators such that consistent information is provided to patients. The letter should clearly state the patient's rights and who to contact if he or she wishes to file a complaint.

ii. We welcome the CC's recommendation that where "*consultants do not provide sufficient information to patients, it would be the hospitals' responsibility to enforce compliance*"[86]. However, in some instances, treatment may be conducted at an outpatient-only clinic (and in some cases the consultant his- or herself may be an owner in this facility). In these circumstances, the CC's proposed compliance

[85] PDR, paragraphs 2.522 to 2.524
[86] PDR, paragraph 2.527

mechanism would not be effective. We recommend, therefore, that the CC proposes a parallel enforcement mechanism for such facilities such as mandatory reporting to the GMC.