

Response of



to

Provisional Decision on Remedies
(Non-Confidential)

Appendix 8

7 February 2014

Remedy 4 – Clinician Incentives

1 Introduction

- 1.1 Whilst we continue to dispute the existence of an adverse effect on competition giving rise to a requirement for this remedy for the reasons set out in our submission on the Commission’s Provisional Findings, BMI Healthcare broadly welcomes the statement of intent set out in the Provisional Decision on Remedies (“PDR”) in the area of clinician incentives. To ensure that these have the desired effect, BMI Healthcare sets out the specific areas which require further thought from the Commission before its final report is published. We comment on these and on each of the categories of clinician incentive referred to in the PDR, below.

2 Commentary

Direct Incentives

- 2.1 The Commission describes as ‘direct incentives’ those “*schemes or arrangements between hospital operators and clinician which link, implicitly or explicitly, the value of the rewards provided to a clinician to the value of that individual clinician’s conduct to the hospital operator*”¹. In order to compete with others offering such schemes – and as previously advised to the Commission - BMI Healthcare [X].
- 2.2 The Commission’s PDR proposes an outright ban on direct incentives. BMI Healthcare is unequivocally supportive of this, and considers there are two further important points the Commission should go on to consider in order to make its proposed remedy effective.
- 2.3 The first of these is that in order to be properly effective, the ban should apply further than simply to private healthcare operators, in fact to all those who provide healthcare goods and services. This would include equipment manufacturers and suppliers of drugs and consumables as well as to diagnostics providers, NHS providers (including NHS-operated PPUs) and operators of cosmetic surgery and fertility facilities (together “Other Operators”).
- 2.4 The second is to specify a reasonable period for unwinding these arrangements and, [X], to put the onus to unwind equally on the private healthcare operator and on the clinician or clinicians concerned. In that regard, we note paragraph 2.400 of the PDR in which the Commission says “[i]t is not clear to us that the outright ban on incentive schemes that we have proposed will result in any costs to the parties”. [X]. It is important, therefore, that the way this remedy is phrased makes clear that it applies also to the clinicians, not just to the private hospital operators.

Indirect Incentives

- 2.5 In its PDR the Commission describes these as “*schemes or arrangements between a hospital operator and clinicians where there is no linkage between*

¹ Para 2.366 of the PDR

*an individual clinician's behaviour and the reward he or she receives.*² The Commission also includes equity arrangements in this category, but in this response we propose to deal with these separately, below.

- 2.6 The Commission has proposed an upper limit of £500 in terms of any such arrangements and has suggested these might include “*free tea and coffee, newspapers and magazines, stationery, general marketing and in-house training*”³. BMI Healthcare is supportive of having some sort of de minimis figure (we note this should probably be inflation-linked) however there are certain costs expended on behalf of consultants which would exceed this £500 figure and which we consider should be specified by the Commission as expressly permitted. These areas of non-discretionary spend can be easily differentiated from those commented on in the ‘payment for services’ category below as there is effectively no choice for private hospital operators as to whether or not they spend in these areas. We discuss these items of non-discretionary spend further, below.
- 2.7 BMI Healthcare also considers the £500 upper limit should apply in relation to Other Operators’ arrangements with clinicians too.

Payment for Services

- 2.8 In paragraph 2.378 of the PDR, the Commission discusses services “*with a higher value (for example, the provision of consulting rooms, secretarial and administrative services, contributions to professional indemnity insurance, and parking spaces)*”. The Commission’s view is “*that where the cumulative value of all services provided to a clinician by a hospital group exceed[s] £500 a year, anything in excess of the £500 limit should be (a) charged to the clinician at their fair market value; (b) potentially available to all clinicians with practising rights at the hospital.... and (c) disclosed on the private hospital operator’s website (by hospital) together with the market value that the hospital operator imputed to each service*”⁴.
- 2.9 BMI Healthcare considers this to be a sensible way forward and is supportive of the Commission’s proposals in this regard, although would suggest again a clear timetable for imposition of this requirement and that the requirement be imposed on Other Providers, too. We think it sensible the obligation to disclose on websites should apply also to the individual clinician/clinicians.
- 2.10 BMI Healthcare also considers it sensible that such limit applies per clinician, per facility, rather than per clinician, per provider to avoid the slightly bizarre situation which might otherwise arise where a single consultant has to pay for tea and coffee at one facility, simply because they happen to practise at more than one facility operated by the same hospital provider.

Non-Discretionary Spend

- 2.11 As noted above, there are a couple of areas which BMI Healthcare does not believe have yet been fully considered by the Commission in its assessment of this area. We do not consider that these act as inducements, but are part

² Para 2.368 of the PDR

³ Para 2.377 of the PDR

⁴ Para 2.379

of a hospital's core delivery. The first of these are the costs of producing electronic or hard copy 'consultant directories', which detail the consultants with practising privileges at different facilities. It is clear that without communicating to GPs, other referrers and the public exactly which consultants practice at a particular facility, a private facility is pretty much doomed, hence this expense being non-discretionary. The costs of CNST⁵ membership or corporate insurance policies which provide cover for providers – and all their staff and consultants - providing services to NHS patients is also non-optional, particularly as it is a contractual requirement when working with the NHS. To be clear, the same does not apply to indemnity or insurance cover for consultants' private practice.

- 2.12 The costs of these would exceed the £500/consultant de minimis limit suggested by the Commission. We have considered whether the Commission's proposed remedy for spend in excess of £500 could apply and whilst BMI Healthcare considers limbs (b) and (c) ('potentially available to all consultants' and 'disclosed on the operator's website') could be met, BMI Healthcare considers it unreasonable for limb (a) (that is, charged to the clinician at fair market value) also to be applied. This is simply because these are non-discretionary spend areas which are simply not an inducement; to require consultants to pay for these puts private hospitals at a distinct – and unreasonable – disadvantage when compared with their NHS competitors, where such non-discretionary spend items are at no charge to individual clinicians.

Clinicians receiving remuneration for services provided

- 2.13 At paragraph 2.380 of the PDR the Commission recognises the possibility of a clinician providing services to a private hospital in exchange for remuneration. The PDR proposes that in such circumstances, the private hospital disclose on its website both the payments made to individual post-holders and a summary of the duties performed by each post-holder on behalf of the private hospital. BMI Healthcare is supportive of this proposal; again, provided it applies equally to Other Providers and the disclosure obligation applies equally to clinicians.
- 2.14 However, what the Commission may be missing is the factual reality that many consultants provide services to a private hospital without any financial payment. A good example of this is the critical role that clinicians play as members – or indeed chairs – of hospital Medical Advisory Committees. BMI Healthcare – in common with, it believes, many of its private healthcare competitors - does not pay individuals for their time and service on a hospital Medical Advisory Committee. These committees form a critical part of the clinical governance structure of private hospitals and are a regulatory requirement. However, it is customary for hospitals to ensure refreshments are provided at such meetings (which take place, because of consultant availability, in the early evenings) and to arrange a dinner each year for members (and their partners) by means of a 'thank you'. In addition, all BMI Healthcare hospital Medical Advisory Committee Chairs are members of BMI Healthcare's National Medical Advisory Committee which holds an annual conference. These are held in a hotel and, as it is over a weekend, partners are also invited to attend. There is generally a partners' programme arranged

⁵ Clinical Negligence Scheme for Trusts

and the conference culminates in a gala dinner for National Medical Advisory Committee members and their partners. BMI Healthcare also has a [redacted].

- 2.15 BMI Healthcare would wish to make it clear that we do not remunerate consultants for providing these services, but in recognition of their time and work, BMI pays for consultants' accommodation and meals for the meeting/conference (and travel expenses, where claimed) and both the consultants' and their partners' meals at the annual hospital Medical Advisory Committee dinner or annual National Medical Advisory Committee gala dinner. Our rationale for involving partners too is an acknowledgement that the times of these meetings/conferences, because of consultant availability, are evenings or weekends, thereby impacting not just the consultant but also their partner and family.
- 2.16 BMI Healthcare considers it appropriate that the Commission require the disclosure of the market value of such accommodation, dinners etc and that these be publicised on the provider's website.

Equity Participation Schemes

- 2.17 In its PDR, the Commission has set out its view that although equity participation for clinicians should be permitted, this should be subject to certain rules. In summary, these are that (a) the equity stake must be paid for by the clinician up front and at fair market value; (b) the equity stake should be limited to 3% for any individual with practising rights at or the ability to commission tests at the facility concerned and (c) the equity stake should not be linked to any referral or practice requirement⁶. BMI Healthcare welcomes the clarity, but considers this area needs expressing in more detail and needs further thought.
- 2.18 Firstly, it is not clear whether the 3% limit applies on a 'per clinician per facility' basis or on a 'per clinician per provider' basis or on a 'per clinician across all private healthcare providers' basis. Secondly, we think it should expressly prohibit participation by GPs and other referrers rather than limit their interest to 3%, given the GMC guidance in this area. Thirdly, we think this restriction should apply to equity participation schemes in Other Providers in the same way as it is currently proposed to apply to equity participation schemes in private healthcare operators. Finally, if there is to be a limit, then the Commission should express it as the beneficial interest itself (rather than simply the equity stake) being limited to 3%, to avoid any trusts being created to benefit a clinician or members of his or her family.
- 2.19 More fundamentally, we are concerned about the likely adverse impact the Commission's current thinking in this area will have in developing services and facilities which would benefit patients and we would welcome the opportunity to discuss this further with the Commission at our coming hearing. By way of example, [redacted].
- 2.20 The Commission has proposed⁷ that private hospital operators be required to disclose details of any equity arrangements in hospital facilities – or equipment within those facilities – on their websites. BMI Healthcare agrees

⁶ Para 2.391 of the PDR

⁷ Para 2.392 of the PDR

with this although considers that the disclosure obligation should apply equally to clinicians. Disclosure could (and probably should) also form part of consultants' GMC revalidation paperwork.

- 2.21 The PDR notes the Commission's provisional view that the unwinding/amending of existing schemes which do not meet the Commission's requirements for equity participation, joint venture or equivalent schemes (we refer to these simply as 'equity participation') should be completed within a period of six months from the date of the Commission's final Order⁸. We think this requires further consideration and a different approach should be adopted depending upon whether or not clinicians have paid market value for their interest.
- 2.22 We agree that investments that consultants have been granted for free, or explicitly in return for shifting their practice commitments for a given period, should be phased out or amended as the Commission proposes. However, where clinicians have already paid market value for their interest, BMI Healthcare considers that it is disproportionate to require their unwinding/amending given that (a) such equity participation arrangements are a small part of the UK private healthcare market, (b) the remedy can in any event apply on a forward-looking basis immediately and (c) the existence and extent of any gain to competition and consumers from breaking up existing equity participation arrangements is far from established. Investments falling into this category made prior to the imposition of the remedy ought to be allowed to run for their course provided, of course, that fair market value was paid for them in the first place. This two-track approach avoids the remedy having harmful retroactive effect where possible. We set out further detail on this in paragraph 2.24 below.
- 2.23 Paragraph 2.403 of the PDR sets out the Commission's views that the unwinding of the equity participation schemes should be "*broadly neutral*" if they take place at fair market value (should either the private hospital provider buy out the clinician or vice versa). We consider the Commission has oversimplified this and the complexity of what are mixed personal and commercial relationships. For this reason, it is probably not a viable option for either party to sell to an incoming third party and in some cases will not be viable for one current party to buy out the other. If a detailed discussion on this issue would be helpful, we would be happy to have this with the Commission.
- 2.24 Taking the points in the preceding paragraphs into account – and mindful of the need to consider the costs of any remedy and that it is proportional - we propose the following:
- (a) in relation to those schemes with equity participation where the clinician has paid market value for their interest, we consider it reasonable that such schemes be permitted to run (i) until expiry of the contract; (ii) until the asset is fully depreciated or (iii) for a maximum of three years from the date of the Commission's final Order.
 - (b) for all equity participation schemes where market value for the consultant's interest was not paid, such arrangements either be

⁸ Para 2.391 of the PDR

terminated or amended to bring them into line with the Commission's requirements within six months of the Commission's final Order.