

COMPETITION COMMISSION MARKET INVESTIGATION: PRIVATE HEALTHCARE

FINAL SUBMISSION FROM CIRCLE

19 FEBRUARY 2014

1. Introductory comments

We welcomed the opportunity to discuss the Provisional Decision on Remedies (“PDR”) with the Competition Commission (“CC”) at the hearing on 10 February. Following the hearing, we set out below some further submissions that we ask the CC to consider in coming to its final decision on the market investigation. These relate primarily to the CC’s Theory of Harm 2 (“tying and bundling”) in relation to which we are eager to help the CC find a workable, proportionate and effective remedy.

2. Prohibition on national discounts

We propose that the CC should prohibit incumbent operators of private hospitals offering price discounts which are based on total national volumes of business provided by any PMI (or any pricing practice with equivalent effect). An operator would still be permitted (and indeed encouraged) to negotiate discounts on either a local or a regional level based on the volume of business that a PMI conducts with the operator in that local/regional market, but would not be able to leverage its national presence to obtain volume commitments across the board (and/or influence PMIs not to negotiate with smaller providers who lack a national network of facilities). An operator would also still be permitted to negotiate base pricing levels on a national basis, to avoid having to enter into individual negotiations for each hospital should it consider this too onerous.

The effect of this remedy would be to remove the link between local market power and national market presence, to ensure that an operator with a significant presence in one locality cannot leverage that presence into its national relationship with any PMI. This would directly address the issues that the CC explores in ToH 2 and would be simple to enforce. It would create a level playing field on which new entrants could compete, thereby reducing barriers to entry. It would also reinforce the reality that competition takes place at local market level, but without any spill-over into the

national picture. We continue to believe that there is a need for an easily accessible, quick and cost-effective dispute resolution mechanism, and refer the CC to our previous submission in which we outlined a role for Monitor in fulfilling this function.

3. Price matching for new entrants

As we have outlined to the CC in previous submissions, and as the CC has recognised in its Provisional Findings, one of the major barriers to new entry is the difficulty in attracting financing, which derives from the lack of certainty as to viability of any new entrant in the private healthcare market. Part of the reason for this is the inherent advantage that an incumbent holds in negotiating pricing and relationships with the PMIs. A new entrant cannot hope to emulate the incumbent when it first seeks to negotiate with a PMI as it does not have the operating history nor the scale to counterbalance to any degree the PMI's buyer power.

To remedy this, we propose that the CC requires the major PMIs to offer the same pricing to any new entrant into the national market that it offers to incumbents, for a period of two years. The price may either be matched based on the price paid to incumbents in the particular local market in which the new entrant opens its hospital, or on the average of the basket of prices in the geographic region of the new hospital.

The outcome of this remedy will be to ensure that the new entrant can compete on a level playing field with incumbents and will force incumbents to compete with the new entrant on quality rather than on price. After an initial two-year period the new entrant should be sufficiently established to negotiate prices directly with the PMIs. Financial backers considering funding a new entrant will therefore have the certainty that, for an initial period, the new entrant will not be forced to pay prices that may prove unviable simply because it does not have the local or national market power or scale of an incumbent.

4. De minimis level for equity incentives

During the hearing on 10 February, we discussed with the CC whether we supported the notion of a de minimis level below which awarding equity incentives in return for a revenue commitment should be permissible.

It remains our view that, where a new entrant seeks to enter the market, it should be permitted to agree revenue commitments with clinicians in return for equity. This could be subject to a two-year time limit, i.e. the revenue commitment would fall away within two years of the relevant hospital opening. However, were the CC minded to impose a de minimis level, we would suggest that this should be set at £10,000 (i.e. the value of the shares at grant could be anything up to £10,000) – enough to reward the clinician for his/her initial commitment but not enough to have any influence on his/her referral behaviour. Such a threshold would strike a balance between the CC's general concern about the influence of incentives on referral behaviour and the beneficial impact of the ownership model on clinical engagement.

5. Concluding remarks

We remain confident that the CC will find a suitable remedy to address ToH 2, and we encourage the CC to take bold steps to deal with the issues that are raised by the tying/bundling theory of harm. We would welcome the opportunity to engage with you further on this, including discussing any of our proposals above.