COMPETITION COMMISSION MARKET INVESTIGATION: PRIVATE HEALTHCARE

RESPONSE FROM CIRCLE TO PROVISIONAL DECISION ON REMEDIES

FEBRUARY 2014

1. Introduction

Circle is disappointed by the Competition Commission ("CC")'s Provisional Decision on Remedies ("PDR"). There has been a significant dilution of the remedies package which, left unaltered, threatens the overall effectiveness of the remedies with which the CC plans to proceed. In respect of some of its conclusions, the CC does not appear to have relied on any evidence and Circle considers that, in failing to address the key issues, the CC has not fulfilled its statutory obligations and the private healthcare sector will remain characterised by a lack of genuine competition and high barriers to entry. This would be a dire outcome for patients who will continue to be denied meaningful choice, clinical innovation and more affordable healthcare.

When Circle first approached the OFT about the private healthcare market in 2010, it expressed its concerns that incumbents with a combination of significant local market power and an extensive national presence could use their market position to distort competition. As a result, new market entrants like Circle did not have the opportunity to compete on a level playing field. This lack of a level playing field made new entry very difficult and therefore entrenched the market power of the incumbents.

In the CC's Notice of Possible Remedies ("Remedies Notice") of August 2013, Circle was encouraged by the package of proposed remedies that had the potential to level the playing field. We saw these remedies working together to dilute the market and pricing power of the major hospital groups that have enjoyed outsized profits at the expense of patients and new market entrants.

However, in the PDR the CC has taken giant steps back from the Remedies Notice on the key remedies: namely divestitures (Remedy 1) and tying/bundling (Remedy 2). [redacted]

[redacted] In relation to both Remedy 2 and equity incentives, Circle has struggled to find any indication that the CC has drawn on concrete facts and evidence to reach its conclusions and final proposals.

As a result, it is Circle's view that the remedies proposed in the PDR do not adequately address the AECs that the CC has provisionally found to exist in the private healthcare market. [redacted]

We set out below our detailed comments on those remedies proposals that we consider to be critical, together with our views on the remainder of the proposals set out in the PDR.[1]

2. Comments on Key Remedy Proposals

2.1 Remedy 1: Divestitures

Circle remains convinced that divestments are a vital tool to help address many of the competition issues identified by the CC in its Provisional Findings and experienced by Circle in the market, many of which stem from the weak competitive constraints in local markets. Circle has had no access to the details of the Commission's LOCI or PCA analysis, nor to the data room, and therefore any comments Circle can make on the divestiture remedy are high level only.

Like many other parties involved, Circle is surprised that the number of facilities and the number of operators that the proposals in the PDR now relate to have reduced so dramatically since the Remedies Notice. Notwithstanding the CC's detailed analysis of each local market, Circle finds it hard to accept that there are c.10 local markets in which the CC provisionally identified an AEC but in respect of which the CC is now not requiring a divestment. In respect of a number of local markets, the PDR notes that there is weak local competition, but concludes that divestiture would not be an effective remedy. No other remedy is proposed to tackle directly those weak competitive constraints. So the conclusion that Circle draws from the PDR is that, in those local markets, the incumbent provider will continue to have a

[redacted]

dominant competitive position and the AEC will continue. Put simply, the divestiture proposals as outlined in the PDR are insufficient.

Circle notes that, in the Provisional Findings report ("PFs"), the CC stated that:

"Our analysis of the drivers of insured price outcomes also shows that higher insured prices are associated with larger hospital portfolios" (PFs paragraph 6.241) and *"higher insured prices at the national level arise because of the lack of sufficient competitive constraints faced by hospital operators at the local level"* (PFs paragraph 6.242).

The CC further found that:

"Considering BMI, Spire, Nuffield and Ramsay, characteristics of hospital portfolios reflecting a lower substitutability to PMIs of hospitals at the local level on average and/or of hospital portfolios as a whole are found to be associated with higher insured prices. BMI and, to a lesser extent, Spire are shown to obtain higher insured prices with PMIs on average than Nuffield and Ramsay, and it is also the case that, on the basis of the characteristics considered, BMI and, to a lesser extent, Spire have hospitals and/or hospital portfolios that are less substitutable..... our view is that having hospitals facing low levels of competition in one or more local areas (i.e. hospitals which are less substitutable for the PMIs at the local level on average) strengthens the position of a hospital operator in negotiations with PMIs and is likely to lead, in the absence of countervailing factors, to higher prices to PMIs at the national level." (PFs paragraph 6.247)

In light of this finding, and the detailed pricing analysis that the CC undertook to determine the relationship between the level of insured prices, local market concentration and national portfolio size, Circle is amazed that the CC is no longer proposing that Spire should be required to divest any of its hospitals.

In the PDR, the CC expresses its confidence that there will be sufficient availability of suitable purchasers to acquire the divested facilities. Yet, we are concerned that the impact of certain of the other remedies proposed in the PDR may undermine this. Specifically, the restrictive conditions on equity investment proposed as part of Remedy 4 (see further below) may make it more difficult – rather than less – for new, smaller operators to operate in the market and may have the effect of deterring them from bidding to acquire any of the divested hospitals. Nueterra, one of the potential new entrants referred to by the CC in the PDR, has

expressed its view that the CC's proposals in the Remedies Notice were disproportionate and insufficiently targeted. In Circle's view, the same is true of Remedy 4 as currently proposed in the PDR.

Circle therefore strongly believes that Remedy 1, as currently drafted, will not fully address the AECs in local markets nor will it encourage or assist new market entry.

Circle also has concerns that either or both of HCA and BMI will challenge the imposition of Remedy 1 in the Competition Appeals Tribunal. Any further dilution of this Remedy as a result of such a challenge will further undermine its effectiveness and the effectiveness of the CC's remedy package as a whole.

2.2 Remedy 2: Constraints on Tying and Bundling

The weakness of the divestiture proposals is compounded by the lack of any proposal to remedy the national bargaining power of the major providers, which is supported by their continued ownership of solus/duopoly or "must have" hospitals. Circle believes that, by failing to provide any suitable remedy to address this issue, the CC is failing to improve competition to any meaningful degree in the private healthcare market.[2] The CC has rejected possible remedies without properly considering their effectiveness and has reached conclusions that appear to have no foundation in evidence.

The CC has rejected the suggestion that divestitures should be required in non-cluster areas to reduce the scale of some of the larger private hospital operators, on the basis that this is not consistent with the CC's provisional findings that the level of national prices is the result of the level of market power held in local areas rather than due to the overall scale of a hospital group (PDR paragraph 2.69). Why, therefore, has the CC not addressed monopoly/duopoly hospitals? Surely the level of national prices, and, more generally, national market power, will continue to be too high if operators continue to have significant local market power in monopoly/duopoly areas.

In the Remedies Notice, the CC proposed two alternative remedies to address the potential harm to competition that may be caused by incumbents exploiting their local market power in areas where they operate either a monopoly or a duopoly hospital when negotiating terms

[2] Similarly, despite stating that the power of incumbent providers to induce PMIs not to recognise a new entrant constitutes a barrier to entry (PF para 6.84), the CC's package of remedies does not offer any practical means of offsetting this power.

with PMIs nationally. However, the CC concluded that the first variant would only address pricing conduct, but not other conduct that might have the same outcome but might be less easy to identify. It concluded that the second variant would not deter operators from monopoly pricing in monopoly/duopoly local markets and that barriers to entry are too high to rely on new entry to undercut this pricing.

Circle understands the reasons why the CC considers that the second variant would be an ineffective remedy, without a price control remedy, which the CC has rejected.[3] However, Circle wholly disagrees with the CC's conclusions on the first variant, for the following reasons.

The CC considered that to enforce the remedy with a general anti-circumvention measure would give rise to numerous disputes, and that any process for resolving such disputes would be "*expensive, complex and intrusive*" and that overall the remedy "*is only likely to be partially effective in addressing the AEC*" (PDR paragraph 3.87). The CC argues that:

"*In previous remedies where we have required the creation of an adjudicator we have been able to specify fairly precisely what conduct was considered to fall within the scope of the measure" (PDR paragraph 3.77)*

The CC states that this would not be the case were it to impose a similar remedy here.

Circle strongly disagrees. The CC has already spent a great deal of time looking at the types of conduct that operators engage in and has a good sense of the potential effects of these. This analysis should therefore enable the CC to draw up a full description of at least these activities that should be prohibited. Simply because the CC is unable to produce a list of prohibited conduct that remains comprehensive in perpetuity does not mean that the remedy should be abandoned. In the field of merger control, for example, it is commonly acknowledged that remedies imposed may sometimes be circumvented latterly, but this is not a reason not to impose such remedies in the first place.

A general anti-circumvention measure is also valuable and Circle does not agree that resolving disputes that may fall within the scope of this measure is automatically more complicated than resolving disputes that fall within the purview of other adjudicators created

[3] Circle continues to believe that some narrowly tailored, time limited price control mechanism would be an effective and relatively inexpensive remedy in this market.

by the CC. For example, the Groceries Ombudsman has an obligation to adjudicate on disputes under the Groceries Supply Code of Practice. This contains an obligation on groceries retailers to:

"at all times deal with its Suppliers fairly and lawfully. Fair and lawful dealing will be understood as requiring the Retailer to conduct its trading relationships with Suppliers in good faith, without distinction between formal or informal arrangements, without duress and in recognition of the Suppliers' need for certainty as regards the risks and costs of trading, particularly in relation to production, delivery and payment issues." (paragraph 2)

Circle strongly asserts that adjudicating disputes under this obligation is no less complicated than adjudicating disputes in the private healthcare market, e.g. whether a provider's arrangements with a PMI imposes terms or obligations that distort the level playing field for fair competition in local markets. An examination of internal documents relevant to the contested decision taken by the respondent would undoubtedly assist the adjudicator in reaching a ruling on the dispute.

The existence of such an adjudicator would be a much cheaper and quicker remedy for this sort of dispute than either a complaint to the OFT/CMA or private litigation. First, there would be no question of case allocation between the OFT/CMA and Monitor and no question as to whether the case falls within the regulators' prioritisation principles. It would therefore immediately be more effective than a complaint made under the Competition Act 1998. The adjudicator could decide on a case by case basis how to limit the evidence that the parties would need to provide, could set a short timetable for consideration, and would not have to seek third party views (unlike the OFT/CMA). Arguments could be made entirely in writing and parties would not need or be able to adduce any expert evidence. There would therefore be a quick and cost-effective way of resolving disputes, making the remedy both effective and proportionate.

Moreover, Circle would suggest that there is no need to create a new adjudicator to carry out any dispute resolution function. Monitor is already in existence, and holds within it considerable healthcare and competition law expertise. It will shortly be required to license private providers who wish to provide NHS services (virtually all major hospital groups do) and the licences it will issue will contain conditions to prevent anti-competitive behaviour which is not in the interests of patients. Furthermore, Monitor has concurrent powers with

the OFT to apply competition law to all healthcare services in England. Therefore it is already empowered to review competition law issues in this sector. Extending the scope of Monitor's remit to deal with disputes on compliance with a remedy that prohibits tying/bundling would draw on this expertise and would therefore be cheaper and swifter than establishing a new adjudicator.

The CC has recognised that the exercise of market power on a national scale creates an AEC. It has also recognised that there are ways to remedy this, although perhaps not comprehensively. However, it ultimately proposes no effective solution. Circle cannot accept that this is a satisfactory outcome of a detailed two year market investigation. The CC has simply assumed that the introduction of an adjudicator would be complex and costly, without – it would seem – any analysis or evidence. As the CAT has noted[4], it is impermissible for the Commission to assume certain outcomes without proper investigation and consideration of the issue. This clearly appears to be the case here. The CC has failed to make any assessment of the proper benefit of a general anti-circumvention measure plus an adjudicator and has failed to take account of the economic costs of such a remedy. In other words there has been no proper balancing exercise undertaken, as is required in the proportionality exercise[5].

If the CC is serious in its wish to encourage and sustain new entry, it cannot abandon the opportunity to remedy one of the major barriers that the market current faces. Without a level playing field no potential entrant will elect to compete in this market and no financial backer will risk an investment in a new entrant that is bound to fail.

2.3 Remedy 4: Clinician Incentives

In respect of the CC's proposed Remedy 4 (Consultant Incentives), Circle is surprised by the extent to which the CC has altered the scope of the remedy since its Provisional Findings. In its PF, the CC concluded that, while consultant incentives generally have an influence over consultant behaviour that contributes to an AEC, equity arrangements that encourage new market entrants should be safeguarded. This position rightly recognised the important role that equity arrangements with consultants have played in enabling new market entrants like Circle and KIMS to attract financing to build new facilities, as well as encouraging clinicians

[4] Tesco PLC v. Competition Commission [2009] CAT 6, paragraph 124

[5] Tesco PLC v. Competition Commission [2009] CAT 6, paragraph 130

to take a more active role in the delivery of care to patients. However, in its PDR, the CC has proposed conditions on these equity arrangements that deviate sharply from the principle set out in the PF. These proposed conditions raise serious questions about the efficacy and impact of the remedy and, when taken together with the rest of the PDR, the CC's overall package of remedies.

Specifically, we believe the proposed conditions: (1) will be ineffective in addressing the AEC identified by the CC; (2) have unintended consequences that would create or exacerbate AEC; (3) do not achieve the desired benefits; (4) impose punitive costs on those providers forced to unwind existing arrangements; and (5) fail to recognise the importance of equity ownership in promoting clinical engagement.

We address each of these shortcomings below and, in response, suggest amendments to the proposed conditions that we believe address the CC's concerns while safeguarding the clinician ownership model.

2.3.1 Direct Incentives

Circle broadly agrees with the CC's conclusion that "direct benefits" – where financial rewards are directly linked to consultant behaviour – are presumptively undesirable. Common examples cited by the CC include cash-for-patient schemes and the provision of medical secretaries, consulting rooms and other in-kind benefits designed solely to induce the consultant to refer patients. These sorts of arrangements are generally bad for competition because they invariably are used by deep-pocketed incumbents to entrench their market position (thereby enhancing their pricing advantage vis a vis the PMIs) and deliver no discernible benefits to patients in terms of the quality of care received. In short, they distort competition without providing any offsetting benefits in terms of price or clinical quality.

Accordingly, Circle accepts the CC's proposal to allow operators to provide de minimis "direct" inducements to consultants of up to £500 annually, and that any direct incentives in excess of this amount be disclosed to patients and paid for by consultants.

2.3.2 Equity is Different

As Circle has long contended, equity is fundamentally different than other forms of incentives extended to consultants and – for the Circle model at least – has different aims.

The purpose of Circle's share scheme is to incentivise clinicians in their work, by asking them to think of themselves as co-owners of their Circle facility so that they will assume managerial, operational, and business development responsibilities that improve the way we can deliver care to our patients and value to our customers (PMIs). Unlike cash-based incentives, Circle shares are not a reward for patients, and therefore are not and never have been a direct incentive.

As the CC notes, equity does not have the causal relationship over the consultant's referral behaviour as cash payments and free medical secretaries do. The value of the shares issued to a consultant in group schemes like Circle's will vary over time; it is affected by a multitude of factors that have nothing to do with the consultant's referral behaviour. As a consultant's equity is "pooled" with those of other scheme members, from nurses to porters to managers, they all realise value in their shares based on the group's overall performance. As a result, a consultant's individual referral behaviour will have no direct impact on the value of his shares and so his equity cannot be said to influence his referral behaviour (or at least not to any degree that would contribute to AEC).

Not only is equity distinguishable from direct incentives, several operators and some PMIs have recognised that it also serves to attract and incentivise consultants in ways that benefit competition. Specifically, equity (1) enables new entrants to attract financing for new facilities, (2) creates an ownership culture that encourages better clinical engagement, which leads to better clinical outcomes, (3) the resulting clinical engagement spurs innovation and investment across all sectors and specialities, which enhances competition among providers to improve clinical services and the overall patient experience. The purpose of shares, therefore, is to encourage broader clinician engagement through ownership rather than simply to reward consultants for treating patients.

While irrelevant to the Circle's equity arrangement with clinicians, we accept the argument that equity in respect of a single facility or JV settings could function more as a direct incentive and, as a result, may be more problematic given the potential for competitive harm identified by the CC. However, we note that this problem is also apparent in smaller specialty practices (e.g., ophthalmology, dermatology, cardiology, MSK) that are exclusively clinician-owned. In this respect, Circle fails to understand why the CC has concluded that clinician-owned operators are exempt from its proposed remedies yet all "private hospital operators" (defined arbitrarily, we think, as a facility offering in-patient services), regardless

of size or market power, are subject to the remedies in equal measure. The distinction is even more mystifying when, referring to the CC's logic underpinning the AEC, the competitive harm created by equity ownership would appear to be more pronounced in these smaller sole-ownership settings where the reward for the referral behaviour is more directly linked.

2.3.3 Proposed Conditions Will Not Enhance Competition

The CC properly accepts the importance for operators in using equity for consultants but concludes that it needs to propose conditions governing how such equity is extended. These conditions prescribe the amount of equity that can be issued to a consultant, the price to be paid upon acquiring the equity, the timing of such payment, and the basis for determining how such equity should be allocated. For the reasons set forth below, Circle believes these proposed conditions are unwarranted, ineffective, counter-productive, and counter-factual.

Specifically, the CC proposes certain conditions on equity arrangements with consultants requiring, inter alia, that shares:

1. Be acquired up front and at fair market value; and

2. Not be linked to any requirement to refer patients or conduct a minimum percentage of work or practice for a specific period of time at a particular facility.

Payment Up-front

We fail to understand the reasoning behind this element of the proposed conditions, as the CC has offered no justification for it, nor any evidence that failure to pay up front has an anti-competitive effect. Again, the AEC identified by the CC in respect of Remedy 4 is the risk that the incentive (here, equity issued to consultants) influences referral behaviour. The time at which a consultant pays for equity is irrelevant to whether the consultant is influenced by the equity and so this requirement would be wholly ineffective in addressing the competitive harm the CC seeks to discourage.

Moreover, the CC appears to have ignored the role of share options and has not explained how this requirement would be applied to options. Options are the right (but not the requirement) to acquire shares in the future at a price fixed at the time of grant. They could be considered a deferred payment mechanism since no "up front" payment is required. They are by far the most popular means of incentivising employees in the UK and are used in some

form or another in virtually every type of major corporate share scheme. The reason for this is that giving shares to employees and consultants as part of an incentivisation scheme would normally create an immediate liability under UK tax rules that, in most instances, can only be satisfied by selling a large proportion of the shares. Options provide flexibility and tax efficiency by enabling the employer to link the award of options to performance and enabling the optionholder to determine when he will exercise his shares and pay the related tax liability. We see no compelling reason why consultants should not be eligible to receive options and otherwise participate in a provider's share scheme on the same basis as all other members.

Payment at FMV

Similarly, we fail to understand – and the CC has failed to justify – the requirement for consultants to acquire equity at FMV. Like the requirement to acquire equity up front, the amount paid for equity does not affect the degree of influence the ownership of such equity would have on a consultant's referral behaviour.

As the CC has not provided any justification for this requirement, we can only assume that the CC is concerned that consultants will "over-treat" or work for only one provider even in the absence of an obligation to deliver revenues to a facility because they have a financial interest in increasing the value of their equity. Yet, both the concern and the condition designed to address it are misplaced with regard to the Circle share scheme (and presumably most other group-based schemes).

First, the value of equity in schemes such as Circle's is influenced by an array of factors, including the performance of multiple facilities with differing private/NHS revenue and profitability profiles, new business opportunities, and – where the equity is listed, as Circle's is – general market conditions. As a result, the ability (to say nothing of the likelihood) of an individual consultant to enhance the value of his shares by over-treating or simply working exclusively at a Circle facility is limited to the point of immateriality.

Second, even if we were to accept the CC's implicit assumption, the remedy proposed is counter-intuitive. A consultant with options/shares acquired at FMV actually has more incentive to over-treat or drive more revenue to the facility than he would with shares acquired at less than FMV because with the latter he is already "in the money", i.e., his shares are worth something at the time of grant. As a result, the proposed remedy's requirement that

options/shares be acquired by consultants at FMV actually has the unintended consequence of encouraging more of the referral behaviour that the CC is seeking to mitigate with this remedy.

Prohibiting Revenue Commitments

The CC also proposes that equity arrangements with consultants cannot be linked to revenue commitments or undertakings to work for a specific period of time at a particular provider, even on a non-exclusive basis. This requirement, left unqualified, does not consider how such revenue commitments can be used to enhance competition by lowering barriers to entry or how such benefits outweigh any harmful effects. Indeed, the remedy would only make sense if one assumes that a level playing field already exists among providers (which it clearly does not).

Far from causing an AEC, equity allocated to consultants based in part on their revenue commitments has enabled Circle [redacted] to attract the necessary financing to build new hospitals. One of the most significant barriers to entry for a new provider is the cost and risks associated with opening a new hospital. Revenue commitments provide assurance to investors that a critical level of consultants would undertake at least some of their clinical work at the new facility. Had those original commitments from consultants not been secured, Circle would very likely not be an operator of private hospitals: private patients in the Bath market today would have no choice; patients in Reading would have less choice; and PMIs would pay more to incumbent operators for treatments provided to their members. It is counter-factual to conclude that those commitments, non-exclusive and time-limited as they were, had any adverse effect on competition.

It is ironic that, despite recognising in its PF that attracting consultants to work at its facilities is a significant barrier to entry for new entrants (PF para 6.83), the CC now proposes to undermine the one tool that entrants like Circle [redacted] used to overcome such a barrier.

For these reasons, Circle believes that equity granted based on or as reward for revenue commitments should be permitted in circumstances where it can be shown to encourage competition (e.g., by attracting investment to build new facilities or make new investment) and is limited in duration (e.g., the commitment falls away within 24 months of a facility's opening).

Circle also requests the CC to confirm that providers may use equity to reward a clinician's overall engagement, including taking into consideration the amount of clinical work performed, provided that it is not the sole basis on which the equity is allocated. Even if equity is awarded in part on the basis of treatment volumes, it will not cause AEC where such equity represents a small overall interest in a hospital group and where the overall allocation is based on an array of criteria, e.g., managerial activities, clinical outcomes, business development, staff and patient feedback, training, etc.

2.3.4 Unintended Consequences of Proposed Conditions

By severely proscribing the use of consultant incentives, the CC seeks to eliminate the influence consultants have on referral behaviour so that operators compete only on price and quality. The problem with this reasoning is that (1) it assumes a level playing field will otherwise exist, (2) quality is driven by the clinical engagement that equity ownership encourages, and (3) operators will not stop competing for consultants.[6]

The reality is that, if the proposed conditions are adopted in their current form, then the CC will simply force operators to compete for consultants in different ways. Consultants inescapably drive patient/treatment volumes so operators still need to attract them. The logical consequence of Remedy 4, taken as a whole, is that operators will begin to employ consultants directly. In doing so, operators will capture the sector's "free agents", who will then effectively work exclusively at the operator's facility. In such a scenario, the remedies proposed by the CC would be ineffectual, as operators would be able to compensate these employees as they see fit (using any combination of cash, equity, and in-kind benefits). This, in turn, will spur an arms race, as operators vie to offer ever more lucrative arrangements with consultants in order to secure their exclusive services and 100% of their patients. Clearly, this would be a bad outcome for competition and for patients.

A more desirable outcome, surely, is for consultants to remain as "free agents", with operators permitted to reward them with equity on any terms they wish provided it is not directly linked to patient/treatment volumes.

2.3.5 Proposed Conditions are Ineffective

[6] Indeed, competition for consultants continues to take inventive forms while the CC considers the propriety of past incentives. Circle is currently aware of at least one operator who has started to offer consultants enhanced payments for NHS work in an attempt to secure their time for private patient procedures at their facilities.

Circle believes the CC's proposed conditions would be ineffective in addressing the competitive harm arising from consultant incentives. First, the conditions relating to FMV and deferred payment have no bearing on the degree to which the incentive influences referrals, and furthermore fails to consider the role of options as a widely accepted incentivisation tool. Second, the conditions could actually discourage competition since the only new entrants (Circle [redacted]) have relied on initial, time-limited revenue commitments to attract financing. Without the ability to assure funders that a proposed facility will attract consultants and patients, it is difficult to see how any further hospitals will get built.

2.3.6 Proposed Conditions are Disproportionate

The costs of the proposed conditions outweigh their limited benefits. The benefits are limited because the two current providers who would be most constrained by the proposed remedy are Circle [redacted], who have demonstrated the importance of revenue commitments from consultants to their ability to raise capital to fund their market entry. Furthermore, the conditions are sufficiently restrictive that they will simply force operators to abandon their existing equity schemes in favour of hiring consultants directly. In this respect, the proposed conditions may actually spur a new, more pernicious AEC, as operators compete to acquire the exclusive services of consultants.

[redacted]

[redacted]

3. Comments on Other Remedy Proposals

3.1 Remedy 3: Restrictions on Expansion

In the PDR, the CC proposes a heavily revised remedy in relation to any proposal for an NHS Trust and a private hospital to enter into arrangements in relation to a PPU. The CC believes that this will be a market opening measure, encouraging new entry and therefore (hopefully) helping to address the AECs arising in monopoly/duopoly areas.

Circle considers that the remedy will, in fact, deter new entry as it is very onerous and is disproportionate. Furthermore, the remedy is based on the premise that there will be many outsourcings of PPUs in monopoly or duopoly areas. However, Circle believes that NHS interest in PPU outsourcing is mainly confined to London. Therefore, this Remedy will do nothing to address the significant local market power of monopoly/duopoly operators outside London.

3.2 Remedies 5-7: Information on Consultant and Hospital Performance

Circle supports the CC's proposal in respect of the provision of hospital and consultant quality information.

Circle is also generally supportive of the proposals for the provision of information on consultant fees. However, there are two issues that Circle wishes to comment on:

- The CC considers that modified Remedy 6 would take the form of an order to private hospitals to require that all consultants provide fee information to patients using standard letter templates provided by the hospital, as a condition of granting practising privileges. Hospital operators would be responsible for ensuring compliance by consultants with this requirement. Whilst Circle acknowledges that it is feasible to include the requirement as a condition of granting practising

privileges, in practice it would be very hard for hospital operators to ensure compliance. Consultants are independent self-employed professionals who run their own business with their own medical secretaries, insurance arrangements, paperwork and letterheads. Circle (and other hospital operators) cannot know for certain what consultants send to their patients, and indeed the requirements of doctor/patient confidentiality mean that no third party can be privy to the contents of such correspondence. Nor is the proposal specific about any requirement to update patients should consultant fees increase or decrease – certainly this should be an obligation on the consultants themselves and not the hospital operators.

- Circle also notes that *"the CC proposes that all private hospital operators in the UK be covered by this requirement"* (PDR paragraph 2.525). In Circle's view, the effectiveness of the proposed remedy package will be significantly limited by the fact that the remedies do not extend to all private clinics, private GPs, PPUs and all other providers of any type of private healthcare in the UK. Not only is there no "bright line" between a private hospital and another type of setting in which private healthcare is provided, but a number of operators have facilities that solely treat patients as day cases, without any in-patient provision. It is unclear whether the CC envisages that these operators would be exempt from the remedies in respect of day-case facilities. Circle would suggest that the remedies package should apply to all providers, not just those providing in-patient facilities. In any event, the distinction is false given current trends in medicine towards treating more and more procedures on a day-case basis. Circle considers that in five years any bright line distinction between day cases and in-patients will be anachronistic.

Conclusion

For the reasons set out above, Circle believes the package of remedies proposed in the PDR falls well short of what is required to rectify the significant barriers to entry and weak competitive constraints that exist in many local markets. The CC has inexplicably diluted the bold and robust set of remedies set out in its PFs, and instead has opted for compromises on key remedies that will, in our view, fail to secure the fundamental changes that patients deserve. [redacted]