SPIRE HEALTHCARE

COMPETITION COMMISSION

PRIVATE HEALTHCARE MARKET INVESTIGATION

RESPONSE TO THE PROVISIONAL DECISION ON REMEDIES

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GLOSSARY OF KEY TERMS

AEC	Adverse effect on competition
IPA	Insured pricing analysis
LOCI	Logit competition index
PCA	Price concentration analysis
PHP	Private healthcare provider
PMI	Private medical insurer
WAMS	Weighted average market share

1. INTRODUCTION

1.1 This submission sets out Spire Healthcare Group's (***Spire***) response to the Competition Commission's (***CC***) Provisional Decision on Remedies (***PDR***). Spire's response to the CC's Provisional Findings (***PFs***) is set out in Spire's submission of 11 November 2013.

1.2 Although Spire continues to have serious concerns about the PFs, Spire welcomes many aspects of the PDR. In particular, the detailed analysis of certain aspects of the market has resulted in a PDR that more accurately reflects important competitive dynamics in private healthcare. This submission focuses primarily on the specific remedy proposals set out in the PDR rather than on the underlying question as to whether there is an AEC.

1.3 Spire addresses each of the CC's proposed remedies below and finally addresses a few important points from the PDR that relate directly to the CC's provisional conclusion that there is an adverse effect on competition (***AEC***) in the private healthcare market.

2. DIVESTITURE OF HOSPITALS

2.1 Spire welcomes the CC's conclusion that no divestiture is required in the Leeds and Liverpool areas. This conclusion reflects the evidence of significant competitive constraints in these areas, which is addressed in more detail in Spire's response to the PFs and Notice of Possible Remedies. A few relevant points from those submissions are highlighted below.

2.2 As the CC has recognised in the PDR, and as Spire set out in its response to the PFs, for each of Spire's "cluster" hospitals, there is at least one strong competitor hospital that is closer than the other Spire facilities providing a significant competitive constraint on the Spire hospitals.[1] The preponderance of the real world evidence of local market conditions provided by all market participants, including PMIs, consultants and operators, shows that Spire's hospitals in the Leeds and Liverpool areas face significant competitive constraints.

2.3 In addition, the conclusion on the Leeds area in the PDR corresponds with the OFT's decision in 2008 regarding Spire's acquisition of Classic Hospitals. Spire recognises the CC's position that "*markets evolve and change over time as does the nature of the analytical tools used by the competition authorities*."[2] In the specific case of Leeds, however, to the extent the market has evolved or changed since the OFT decision, this has resulted in an increase rather than a decrease in the competitive constraints on Spire (*e.g.* Nuffield Leeds has developed a paediatric offering, ✂ BMI Huddersfield has introduced new management). As such, the OFT's conclusions following its in-depth review of this area remain a relevant point of reference.

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1 Spire Response to Provisional Findings at para 1.26(c).

2 Competition Commission, Provisional Decision on Remedies at para 2.93.

Spire Leeds Hospital

2.4 Spire understands that, "*following a review of the competitive constraints acting on the hospitals in the area*" the CC has concluded that the "*Spire Leeds Hospital is sufficiently constrained by the Nuffield Leeds Hospital.*"[3] Spire concurs with this assessment, which is supported by the preponderance of the real world evidence of local market conditions provided by all market participants including PMIs and operators.

2.5 As set out in Spire's previous submissions, Nuffield Leeds is very similar in size to Spire Leeds, offers a broad range of services and advertises itself as "*a leading provider of private healthcare in the Yorkshire area.*"[4] ✂

2.6 In addition to the evidence discussed in the PDR, Spire has also provided further specific uncited evidence of competition between Spire Leeds and Nuffield Leeds that bolsters the CC's conclusion. For example, Spire Leeds accelerated development of its paediatric offering to compete with Nuffield Leeds.[5] In addition, as the CC is aware, ✂, providing clear and concrete evidence that customers view these hospitals as competitive substitutes.[6] AXA PPP confirmed this point, telling the CC that it did not support the divestiture of any of Spire's hospitals in the Leeds area as it believed that "*Nuffield Leeds and Spire Leeds effectively constrained one another.*"[7]

2.7 As well as the constraint from Nuffield Leeds, the CC's final decision should also reflect fully the evidence of competitive constraints on Spire Leeds from several other facilities ✂

Spire Elland

2.8 Again, Spire concurs with the CC's conclusion that "*the distance between Spire Elland and Spire Leeds, combined with the proximity of both BMI Huddersfield (to Elland) and Nuffield Leeds (to Spire Leeds), meant that [divestment of Spire Elland] was likely to have a minimal impact on the level of competitive constraint acting on Elland.*"[8]

2.9 As recognised by the CC, ✂.

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3 Competition Commission, Provisional Decision on Remedies, Appendix 2(2) at para 197.

4 Spire's Response of 1 July 2013 to the CC's Assessment of Hospitals of Potential Concern, comments on Spire Leeds.

5 Spire Response to Provisional Findings at para 1.16.

6 ✂.

7 Competition Commission, Provisional Decision on Remedies, Appendix 2(2) at para 208.

8 Competition Commission, Provisional Decision on Remedies, Appendix 2(2) at para 210.

2.10 The CC's final decision should also recognise broader evidence of effective competitive interactions. Spire Elland has taken several steps specifically to compete ✂.[9] ✂.

2.11 ✂. Further, as noted by the CC, Nuffield Leeds, which sufficiently constrains Spire Leeds, is closer to Spire Elland than Spire Leeds is, and is a much larger facility than Spire Elland.

Spire Methley Park

2.12 Spire also concurs with the CC's conclusion that "*the divestiture of Spire Methley Park was unlikely to be effective in significantly increasing the competitive constraint acting on the facility due to the location of Nuffield Leeds between Spire Leeds and Spire Methley Park and the view of the insurers that these hospitals did not act as substitutes for one another*."[10]

2.13 In addition to Nuffield Leeds, which the PDR recognises as a constraint on Spire Methley Park, the majority of Spire Methley Park patients have access to ✂.[11] This concrete analysis of patient catchment areas is consistent with the views expressed by AXA PPP which supported the view that customers do not see Spire Leeds and Spire Methley Park as substitutes for each other.[12]

2.14 The PDR is unclear as to whether the lack of substitutability between Spire Leeds and Spire Methley Park for insured patients also holds true for self-pay patients.[13] This is certainly the case: there is no evidence on which to conclude that self-pay patients would view these two facilities as close alternatives while insured patients do not. In fact, there is evidence that self-pay patients may be willing to travel further than insured patients and thus have access to an even larger range of competitors.[14]

2.15 The CC's final decision should draw on this factual analysis since it is consistent with the outcome of the CC's self-pay concentration analysis. The PCA does not show a statistically significant relationship between self-pay prices and concentration for Spire, and there is thus no evidence to suggest that Spire currently charges higher prices to self-pay patients in areas such as ✂. The evidence presented by the CC in its Provisional Findings does not support the view that divestment of Spire Methley Park (or any other Spire hospital) would lead to lower prices for self-pay patients.

Spire Liverpool / Spire Wirral / Spire Cheshire

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9 ✂.

10 Competition Commission, Provisional Decision on Remedies, Appendix 2(2) at para 213.

11 ✂.

12 Competition Commission, Provisional Decision on Remedies, Appendix 2(2) at para. 108.

13 Competition Commission, Provisional Decision on Remedies, Appendix 2(2) at para.211.

14 GFK, Survey of Patients – November/December 2012 conducted on behalf of the Competition Commission at pp 18, 48 and 49.

2.16 Following review of "*the applicability of AECs to the local markets in which we are considering divestitures based on parties' views and further research and analysis*", the CC has confirmed its conclusion that no divestiture is required in the Liverpool area.[15] This assessment is consistent with real world evidence of market conditions, as set out in more detail in Spire's prior submissions.[16] It is also consistent with the OFT's detailed assessment of the area in 2008, and local competitive conditions remain largely unchanged and, to the extent conditions have changed, local competitive constraints have increased.

(a) All three Spire hospitals operate in competitive environments and face significant competitive constraints from local rivals. Patients therefore have the choice of a range of competing facilities ✂.

(b) Diversion between the Spire facilities cannot be significant. All three Spire facilities in the area have at least one rival that is closer and therefore better able to capture diverted patient volumes than the other two Spire facilities: ✂.

3. REVIEW OF PPU ARRANGEMENTS WITH PRIVATE HOSPITAL OPERATORS

3.1 Spire welcomes the CC's revised approach to Remedy 3, which addresses many of Spire's concerns with the original version of Remedy 3, as set out in the Notice of Possible Remedies. Although Spire continues to believe that no remedy at all is justified, Spire agrees with the CC that the number of PPUs may increase as a result of the lifting of the cap on the amount of private income a Trust could earn as a result of the Health and Social Care Act 2012. As set out in Spire's response to the PFs, the lifting of the cap has already led to a significant number of NHS Trusts exploring opportunities to generate additional private revenues. Spire anticipates that this trend will continue and that there will be significant opportunities for private operators to partner with NHS Trusts to operate PPUs in the future. In fact, 18 hospitals have announced plans to increase private provision since the lifting of the cap on private patient revenues.[17]

3.2 A case-by-case review of potential arrangements is a practicable way of creating additional opportunities for entry by new providers to a given geographic area. Competition concerns can be adequately addressed through extension of the existing merger control regime to cover all proposed PPU partnerships / arrangements. As the CC points out, the SLC test would have the advantage of enabling all relevant circumstances to be taken into account in the competitive assessment, including the dynamic effect of competition and relevant customer benefits. Neither of these latter points could be satisfactorily addressed by a hard and fast rule.

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15 PDR paras. 2.3 and 2.8.

16 See Spire's Response of 1 July 2013 to the CC's Assessment of Hospitals of Potential Concern, comments on Spire Liverpool, Cheshire and Wirral, and Spire Response to Provisional Findings, Confidential Annex 2: Local Assessments.

17 http://m.hsj.co.uk/5067095.article.

3.3 The revised remedy largely addresses Spire's concerns with the original proposal.

(a) **The remedy overcomes issues of practicability and cost**: Eligibility for a PPU bid does not now depend on the inherently complex and uncertain identification and ongoing review of Single and Duopoly areas, but is subject to a more practicable competition law test.

(b) **The remedy ensures that, subject to genuine competition concerns, all providers can compete for PPU contracts on a level playing field.** The remedy removes any artificial bar to the establishment of PPUs by allowing the NHS to partner with a local operator (subject to competition clearance), thereby maximising the chances of the NHS securing the required investment for patients.

(c) **The OFT/CMA would indeed be best placed to review such arrangements as an existing competition authority with experience of applying the SLC test and published guidance and precedents.**

3.4 In the interests of certainty and lower transaction costs, Spire supports the idea of including in the remedy a 'safe harbour' provision, which would relieve from further scrutiny transactions that do not give rise to an increase in the private hospital operator's share of supply of inpatient beds in the relevant area to more than 25%. Spire would suggest that in order to provide certainty for reviewing agencies, the NHS and operators, this safe harbour be based on traditional market share measures in pre-defined geographic radii. A safe harbour based on a LOCI measure, for instance, would not be effective because neither the NHS nor the private operators (nor even the reviewing agency without compelling production of the information) would have sufficient information to calculate a hospital's LOCI. Spire also questions the theoretical merit of the LOCI measure.

4. PROHIBITION AND RESTRICTIONS ON CLINICIAN INCENTIVE SCHEMES

Overview

4.1 Spire's business is based on competing for patients on quality and cost. Spire agrees with the general principle that hospital operators should not be permitted to offer economic incentives to consultants solely for purposes of incentivising them to refer patients to their facilities.

4.2 Spire welcomes the overall approach to arrangements with consultants set out in the PDR. A disclosure-based monitoring regime – overseen by an independent regulator – is clearly the most effective and proportionate way of achieving the CC's stated aims.

4.3 The Proposed Remedy attaches to a wide variety of arrangements and entities and will have a significant impact on the day-to-day business of private hospital operators. In finalising the design of the remedy, it will be imperative to ensure that the remedy is both workable in practice (particularly in relation to the administrative

demands that it imposes) and sufficiently clear and precise to deliver the level playing field between operators sought by the CC.

4.4 Spire therefore proposes the following amendments to this Proposed Remedy that would support these objectives and ensure the remedy is focused on those arrangements that are considered to possibly affect referral patterns.

• **Services provided by hospitals <u>that are not benefits to consultants</u> should fall outside the scope of the Proposed Remedy**. • These would include services intended to ensure patient well-being and clinical safety (e.g. training sessions), and low value services provided to consultants on the same basis as to other staff and/or patients (e.g., parking, food). • Services carried out by private hospitals in the ordinary course of their day-to day activities should also be excluded, including where they might have some incidental impact on consultants (but could not constitute a referral incentive).
• **<u>The disclosure requirements for "services of low value"</u> should be streamlined to achieve a more proportionate and effective approach that ensures appropriate information is available to all stakeholders**. • A private hospital could offer consultants a specified standard "basket" of low-level services/benefits deemed to have a certain value (e.g. marketing), which could then be disclosed on the hospital's website as a standard basket available to all consultants. • The proposed annual limit on provision of such services to consultants should be increased from £500 to £1500.
• **<u>The disclosure requirements for "services of higher value"</u> should also be streamlined to achieve a more proportionate yet effective remedy**. • A hospital could provide an itemised list of all higher value services/benefits on its website, showing the price charged for such services (which would be (i) fair market value and (ii) available to all consultants with practising rights at the hospital).
• **<u>Payments to consultants for services provided to a hospital or operator should not exceed fair market value for the service concerned.</u>**

4.5 Spire's proposals and requests for clarification are focused on ensuring that the remedy is both workable in practice (particularly in relation to the administrative demands that it imposes) and sufficiently clear and precise to deliver the level playing field between operators sought by the CC. These comments are set out below under the following headings:

(a) The design of the Proposed Remedy should follow a clear and workable model that can be effectively applied and understood by market participants;

(b) The implementation of the Proposed Remedy should result in market outcomes that can be easily monitored by market participants;

(c) The proposed disclosure requirements should themselves be workable and ensure that the CC's objectives are achieved in a proportionate manner; and

(d) There are a number of aspects of the Proposed Remedy on which further guidance and/or clarification from the CC would be useful.

A. The Design Of The Proposed Remedy Should Follow A Clear And Workable Model That Can Be Effectively Applied By Market Participants

4.6 It is essential that the design of the Proposed Remedy follows a clear and workable model that can be effectively applied and understood by market participants and ensures that a level playing field is in place between hospital operators. As experience with the Stark Law in the US has shown, rules that are poorly designed can create uncertainty and disproportionate compliance costs for market participants, and result in a perpetual "cat and mouse" game of finding and closing loopholes.

4.7 **In practice, private hospitals enter into a wide variety of arrangements with consultants.** A co-development arrangement with a consultant to cultivate or grow a particular practice area or service can be constructed using (one or more of) a number of different mechanisms, such as revenue or profit-sharing mechanisms, service payments, leases (and sub-leases), non-compete clauses (including restrictions on acquiring shareholdings in competing businesses), equity arrangements, and other restraints such as "lock in" provisions restricting when shares in a business entity might be transferred. The wide variety of marketplace arrangements means that particular precision is required in respect of remedy design in this area.

4.8 **The CC's current categorisation of incentive arrangements is unclear and may be liable to circumvention.** The "*assessment*" of incentive schemes in the PDR focuses on two categories of arrangement, "*direct incentives*" and "*indirect incentives*."[18] It appears, although it is not explicitly stated, that all "*direct*" incentives will be prohibited, but that "*indirect*" incentives will be permitted in the certain specified circumstances (set out in the Proposed Remedy). However, in the "*design*" of its remedy, the CC uses a different categorisation, instead distinguishing between four different types of arrangement: (1) "*Services of low value*;"[19] (2) "*Services of higher value*;"[20] (3) "*Schemes which incentivise patient referrals*;"[21] and (4) "*Equity participation schemes*."[22] How these categorisations fit into the

[18] "*Direct incentives*" are described as "*schemes or arrangements between hospital operators which link, implicitly or explicitly, the value of rewards provided to a clinician to the value of that individual clinician's conduct to the hospital operator*" (PDR, para. 2.366 (emphasis added)). "*Indirect incentives*" are described as "*schemes or arrangements between a hospital operator and clinicians where there is no linkage between an individual clinician's behaviour and the reward he or she receives*" (PDR, para. 2.368 (emphasis added)).

[19] PDR, paras. 2.376-2.377: "*Services or benefits offered by a private hospital to a clinician valued at less than £500 per year*."

[20] PDR, paras. 2.378-2.380: "*Services or benefits offered by a private hospital to a clinician valued at more than £500 per year and services provided by a clinician to a private hospital in exchange for remuneration*."

[21] PDR, paras. 2.381-2.382: "*Any scheme operated by a private hospital operator, whether contractual or not, that provides an inducement to, or creates an obligation on, a clinician to treat or refer patients for tests at its hospital*."

[22] PDR, paras. 2.383-2.392: "*Schemes through which a clinician acquires an equity stake in a vehicle or entity created by a hospital operator*."

distinction between "*direct incentives*" and "*indirect incentives*" is insufficiently clear. It is also not clear how "grey area" arrangements that do not fall cleanly into the four types of arrangement described in the CC's "*design considerations*" should be treated.

4.9 **The Proposed Remedy should provide a clear framework to assess compliance.** In short, the Proposed Remedy should make clear what types of arrangement are prohibited outright, what types of arrangement may be permitted if they meet specific conditions, and what types of arrangement fall outside the scope of the Proposed Remedy altogether and therefore remain acceptable practice.

4.10 Based on a broader reading of the CC's analysis of consultant incentives, Spire understands that the CC's approach may be as follows:

(a) All so-called "*direct incentives*" – *i.e.*, arrangements that provide a link between the value of the rewards provided to a clinician and the value of that individual clinician's conduct to a hospital operator – are prohibited. The arrangements that are prohibited under this head include not only the specific types of direct arrangement outlined in the PDR,[23] but also any other arrangement that has a similarly direct link between consultant remuneration and the value of a consultant's actions to a hospital.

(b) All so-called "*indirect incentives*" – *i.e.*, arrangements between hospital operators and clinicians under which a clinician receives services or benefits – are also prohibited, unless they fall within – and meet the qualifying conditions for – one of the three categories of exemption set out in the Proposed Remedy for services of low value, services of higher value, and equity participation schemes.

(c) The CC similarly seems to intend to capture situations where a clinician provides services directly to the hospital and the hospital pays the clinician for services rendered (e.g. where a hospital employs and pays a radiologist to conduct MRI and CT scans). Spire understands the exemption for services of higher value applies provided the payment for services rendered and a summary of the duties performed is disclosed on the hospital's website.

(d) Any arrangement that does not constitute a direct or indirect incentive scheme between a private hospital and a clinician does not fall within the scope of the Proposed Remedy (and is therefore not subject to the prohibitions and restrictions contained therein).

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[23] *See* PDR, para. 2.367. The examples provided are: "*(a) cash payments made to clinicians for each patient referred or test commissioned; (b) payments made to clinicians equivalent to a set share of revenues generated from each patient referred for tests or treatment; (c) hospital profit share schemes through which the consultant receives a share of the hospital's overall profits depending on the amount of revenue he or she has generated for the hospital; (d) equity participation schemes where the value of shares allocated to a consultant is based on the revenue they generate at a hospital; and (e) schemes providing consultants with discounted or free use of consulting rooms, secretarial and other administrative services where the value of the benefits provided is, implicitly or explicitly, linked to the amount of revenue generated by the doctor concerned*."

4.11 If this is an accurate reflection of the CC's objectives, then this should be more clearly reflected in the construction of the Proposed Remedy.

B. The Implementation Of The Proposed Remedy Should Result In Market Outcomes That Can Be Easily Monitored By Market Participants

4.12 A transparent system that supports easy monitoring will increase the possibility of violations being reported. Resulting benefits would include a lesser likelihood of violations occurring in the first place and greater clarity for consultants as to the feasibility of particular arrangements proposed by hospitals.

C. The Proposed Disclosure Requirements Should Be Workable And Proportionate

4.13 The disclosure requirements in the Proposed Remedy must be workable and proportionate. Detailed item-by-item, day-by-day, consultant-by-consultant, hospital-by-hospital disclosure of *de minimis* items would impose a wholly disproportionate regulatory burden. In keeping with the CC's published guidance, the disclosure requirements imposed should be "*no more onerous than needed*" to achieve the aim of the Proposed Remedy.[24] As explained below, Spire is concerned that the CC's proposed approach does not pay due regard to this principle. Spire proposes below alternative ways in which the CC's objective could be achieved in a practicable, effective and proportionate way.

4.14 **As a starting matter, the Proposed Remedy should make clear the circumstances in which services provided in a hospital are considered to "benefit" a clinician.** The PDR indicates that the Proposed Remedy applies to "*any service or benefit offered or provided to a clinician*."[25] This "gateway" point could be overly inclusive; the descriptions provided in the PDR indicate that such services/benefits include "*free tea and coffee, newspapers and magazines, stationery, general marketing, and in-house training*,"[26] as well as "*the provision of consulting rooms, secretarial and administrative services, contributions to professional indemnity insurance, and parking spaces*."[27] However, the PFs and PDR indicate that the CC's concern is with incentive schemes operated by private hospital operators which encourage patient referrals for treatment at their facilities.[28] Accordingly, the CC's goal should be to design a remedy specifically aimed at preventing hospital operators from offering to consultants any incentives which were intended to or have the effect of encouraging consultants to refer patients to, or treat them at, its hospitals, as opposed to capturing every conceivable "benefit".

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[24] *See, e.g.*, Competition Commission, *Guidelines for market investigations: Their role, procedures, assessment and remedies*, para. 344.

[25] PDR, para. 2.376.

[26] PDR, para. 2.377.

[27] PDR, para. 2.378.

[28] PDR, para. 2.281.

4.15 **The CC's proposed approach appears to capture services/benefits that have no effect on referral patterns, and should not be characterised as "benefits".** Such services should fall outside the scope of the Proposed Remedy altogether and should not count towards the annual limit on services a hospital could provide to a clinician. For example:

(a) **Services intended to ensure patient wellbeing and clinical safety** (e.g. in-house training, including basic/advanced life support or infection control, GMC revalidation, the provision of nurse escorts, and the transportation of outpatient notes). These services are essential to maintaining clinical quality standards and to the provision of private hospital services in themselves. Therefore, these services should not properly be characterised as a "benefit";

(b) **Low value services that are provided to consultants on the same basis as to other staff and/or patients at the hospital** (e.g. provision of free tea/coffee, parking spaces, subsidised meals in the staff canteen). Such benefits should not be categorized as incentives at all and should fall outside the scope of the Proposed Remedy altogether.

(c) **Services carried out by private hospitals in the ordinary course of their day-to-day business activities** that also have some incidental impact on consultants working in those hospitals. Examples of such services include billing activity, GP engagement activity, general hospital promotional events (*e.g.*, to promote a new specialism offered at a hospital)[29] and website support. These are activities carried out by Spire in the ordinary course of operating a hospital, that the hospital would carry out in any case (irrespective of the value of a consultant's performance to the hospital), and any benefit accruing to clinicians would be extremely modest (and could not possibly constitute a referral incentive). These services should not qualify as services or benefits "*offered to or provided to*" clinicians within the meaning of the Proposed Remedy either.

4.16 Given the range of activities carried out in private hospitals that will have some bearing on the consultants that work there, it may not be feasible to exhaustively list all of the services/benefits that fall within (or outside) the scope of the remedy. Accordingly, in addition to clarifying how the activities listed above should be treated, further guidance should be provided, in particular, in relation to:

(a) the circumstances in which day-to-day business activities carried out by a hospital will be considered to benefit consultants; and

(b) how the value attributable to a service/benefit provided by a private hospital that benefits both the hospital and a consultant should be allocated.

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[29] As part of its day-to-day operations, Spire markets its services to GPs, other potential referrers and the general public, sometimes with the participation of consultants.

4.17 Spire notes that the CC has not addressed genuine "corporate hospitality" provided to clinicians by private hospital operators. Spire believes that the sector would benefit from confirmation that corporate hospitality that is both proportionate and not tied to referrals falls outside the scope of the Proposed Remedy. Alternatively, if corporate hospitality is considered to be an incentive, then consistent with other economic sectors it should be a permitted incentive provided it falls within the annual limit on services a hospital can provide to a clinician. This of course depends in part on the CC setting that that limit at a pragmatic level: as Spire notes below, £1500 annually would be a more realistic limit given the CC's objective.

4.18 **If the CC disagrees with the approach above, then any disclosure requirements for "*Services of low value*" must be workable and proportionate.** The CC rightly recognises that services below a certain value are unlikely to have any effect on the behaviour of a consultant and therefore would not constitute an incentive.[30] In addition, there will be a material "*regulatory burden*" in complying with the disclosure obligations envisaged.[31] However, the costs of complying do not appear to be taken into account in the assessment of the proportionality of the Proposed Remedy.[32] These costs are potentially significant and therefore must be taken into account in framing the precise disclosure requirements.

4.19 The CC indicates that the £500 limit is intended to cover low-level benefits such as "*free tea and coffee, newspapers and magazines, stationery, general marketing, and in-house training*."[33] Requiring detailed item-by-item, day-by-day, consultant-by-consultant, hospital-by-hospital disclosure for low-level benefits that the CC recognises are unlikely to have any effect on consultant behaviour would impose a wholly disproportionate regulatory burden.

4.20 Spire suggests as an alternative approach that a private hospital should be able to offer consultants a specified standard "basket" of low-level services/benefits which are deemed to fall below a certain value,[34] which could then be disclosed on the hospital's website on a general basis (e.g. a statement that free tea and coffee is made available to all consultants practising at the hospital, rather than separately disclosing the daily provision of tea and coffee to each individual consultant).[35] There is no need

30 PDR, para. 2.376.

31 PDR, para. 2.376.

32 *See* PDR, paras. 2.396-2.404.

33 PDR, para. 2.377.

34 The deemed value for the specified standard basket would need to be set at a pragmatic level, otherwise the CC's suggested £500 annual cap on lower level services would be regularly exceeded simply by deemed value services. Spire's proposals of identifying services that fall outside the scope of the Proposed Remedy (see above) and also raising the annual cap from £500 (see further below) represent effective and more proportionate solutions.

35 Such a declaration might take the following form: "*[Private Hospital] makes available a range of low-value services to all consultants with practicing rights at the hospital. These services comprise free (or subsidised) on-site food and drink, newspapers and magazines, stationery, general marketing services, and in-house training. The cumulative value of these services (and any other incidental services or benefits not listed individually below) does not exceed £[x] per consultant per year*."

to itemise these services/benefits individually to ensure the effectiveness of the remedy, in particular because, as stated in the PDR, "*the likelihood that services so inexpensive would influence doctor behaviour would* […] *be low.*"[36] Disclosing information about low-level services/benefits in this form would clearly provide the transparency required for interested parties to verify whether the value of such services could possibly rise to the level of influencing consultant behaviour.[37]

4.21 **If the CC is not minded to alter its approach to "*Services of low value*", the £500 limit proposed is not sufficient to achieve the CC's stated objectives.** The £500 limit proposed for "*services of low value*" that need not be re-charged to clinicians appears to be based on two grounds:

(a) It is intended to be sufficient to enable hospitals to make low-level everyday benefits (*e.g.*, tea and coffee, newspapers and magazines, stationery, general marketing, and in-house training) available to consultants without imposing excessive reporting requirements; and

(b) It is intended to be set at a level below which the value of any services/benefits provided to clinicians should not constitute an incentive (because services/benefits of such low value would be likely to have no effect on their behaviour).

4.22 Of course, whether or not a £500 limit is suitable to achieve both of the above objectives depends entirely on what activities fall within the scope of the Proposed Remedy.[38] If one excludes from the scope of the Proposed Remedy benefits/services that are intended to ensure clinical safety and patient wellbeing, or which are provided to consultants on the same terms as other staff or patients (for an illustrative list, see para. 4.15), then the proposed £500 limit seems reasonable.

4.23 However, on the basis of the services/benefits that the CC has currently indicated fall within the scope of the Proposed Remedy, the £500 limit is not sufficient. This is especially the case given the lack of clarity around what falls within the scope of the Proposed Remedy and whether services/benefits are valued at cost or fair market value, which make it very difficult to accurately estimate the cumulative value of such services/benefits. The CC should also take into account that setting a low annual limit might have the perverse effect of disincentivising consultants from accepting certain benefits: for example, "training" benefits (depending on their nature) might have a significant market value and consultants might be disincentivised from accepting them if this would be perceived as an adverse disclosure, leading to a consequential diminution in levels of clinical care.

4.24 Spire therefore suggests that the limit for "services of low value" should be set at £1,500 (which should of course be index-linked). Any services/benefits of this value would clearly not be capable of constituting a referral incentive (*e.g.*, to use the

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[36] PDR, para. 2.377.

[37] PDR, para. 2.377.

[38] *See* paras. 4.15-4.16 above.

CC's measure, this would still be equivalent to less than 2% of a consultant's starting NHS salary and, obviously, far less than 2% of a consultant's combined NHS and private revenue).

4.25 **While more detail should be provided about *"Services of higher value,"* the level of disclosure required must still be workable and proportionate.** The CC suggests that "*services of higher value*" are capable of constituting an incentive to refer and therefore that any higher-value services provided to consultants, such as "*the provision of consulting rooms, secretarial and administrative services, contributions to professional indemnity insurance, and parking spaces*,"[39] over the £500 limit should be declared on a hospital's website. Again, requiring detailed item-by-item, day-by-day, consultant-by-consultant, hospital-by-hospital disclosure would impose a wholly disproportionate regulatory burden.

4.26 **Spire therefore suggests that private hospitals should provide an itemised list of all higher value services/benefits available at a hospital on its website, indicating the price charged for such services and declaring that these services are charged at fair market value and available to all consultants with practising rights at the hospital.** This would clearly meet the CC's objectives (whilst minimising the "*regulatory burden*" on hospitals) in particular because:

(a) There is no need to individually identify the value of such services received by an individual consultant, because all services provided at the hospital must be both charged to the clinician at fair market value and available to all clinicians with practising rights at the hospital. (The CC presumably does not suggest that supplying a particular volume of services at fair market value could ever constitute a referral incentive.)

(b) Sufficient "transparency" would be provided to enable third parties to be able to verify whether a hospital might be providing services to consultants on terms that could constitute a referral incentive.

4.27 By way of example, Spire provides a pro-forma of how a hospital declaration compiled on the basis described above might look in **Annex 1**.

4.28 **Finally, a period of three months from the CC's order should be allowed for implementation of the Proposed Remedy**. In order to implement the remedy, PHPs will be required to assess the fair market value of a range of services, agree terms for provision and payment with clinicians, and put in place systems to monitor compliance. These administrative processes are not straightforward and will require some time to implement across a network of individual hospitals and several thousand consultants.

D. Specific Aspects Of The Proposed Remedy Require Further Guidance And/Or Clarification

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[39] PDR, para. 2.378.

4.29 There are a number of specific aspects of the Proposed Remedy that require further guidance and/or clarification from the CC in order to be capable of effective implementation. These are summarised in **Annex 2**. Spire would be happy to work with the CC to explain any of these issues in more detail and to provide a practical perspective on how the CC's objectives might best be achieved in each case.

5. PUBLISHING INFORMATION ON HOSPITAL AND CONSULTANT PERFORMANCE

5.1 Spire fully supports efforts to increase the information available to patients regarding the quality of private healthcare in order to support patient decision-making. Spire has already taken a leading role in publishing performance information on its own website (since 2007, ahead of publication by NHS Choices) and in supporting the development of the Private Healthcare Information Network (***PHIN***) in order to make such information available to patients.

5.2 Spire has had the opportunity to review the submissions made by PHIN with respect to Remedies 5 through 7 and fully supports those submissions. There are a few additional points that Spire believes it would be useful to clarify, which are addressed below and in **Annex 3**.

5.3 First, the information remedies must ensure that the enduring purpose of the information organisation is to assist patients in making decisions about their healthcare through the provision of information. The range of information to be published should therefore be determined by the factors that *patients* perceive as being relevant to their decision-making. There may be competing interests within the organisation's membership base ✂. The inclusion of a non-executive member representing the interest of consumers and non-executive members nominated by the CMA should assist in achieving this objective, but it will be important to set out specifically the objectives of the organisation in the terms of the remedy to ensure its effectiveness.

5.4 Second, the remedy must also be structured in a way that ensures adequate data and privacy protection for patients. The PDR suggest that the data "*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.*"[40] While Spire fully supports the objective of making data available to support patient decision-making, given the sensitivity of patient data, privacy considerations must trump an interest in providing broad access to a wide group of interested parties. It is essential that adequate data security provisions be put in place not only to ensure that the raw data does not include details identifying patients, but to ensure that it does not include information that would permit a user to combine the organisation's raw data with another data source to identify patients.

5.5 In order to regulate access to and use of the data appropriately, and to generate revenue to support the operation of information organisation, Spire would suggest that

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[40] Competition Commission, Provisional Decision on Remedies at para 2.466(f)

the information organisation license access to its database and establish standard terms and conditions for the license.

5.6 Finally, Spire anticipates that stakeholders are likely to use excerpts from the PHIN data and analysis for a variety of purposes. Spire would suggest that the CC require stakeholders publishing selected excerpts of the PHIN data and analysis to clearly state that a broad range of quality data is available through PHIN (and link back to PHIN where the data is provided in an electronic medium). Such an approach would help to raise patient awareness of the availability of data to assist their decision making and help to ensure that patients can access an objective and unbiased version of the data.

6. PROVIDING CONSULTANT FEE INFORMATION

6.1 Spire supports efforts to increase the information available to patients regarding the cost of private healthcare in order to support patient decision-making. The PDR suggests that consultants will be required to provide a patient with a complete fee quote for an initial outpatient consultation after receiving a referral letter.

6.2 There are a few practical considerations that should be taken into account in designing the remedy:

(a) The timing of the provision of this information may limit its utility to patients: if a patient is unhappy with the fee quote for an initial outpatient consultation, the patient may need to return to his or her GP a second time to obtain a referral to a different consultant.

(b) Outpatient appointments may be booked by a consultant's medical secretary who may be located outside the hospital where the appointment takes place, preventing the hospital from effectively monitoring compliance.

(c) A course of treatment may involve multiple outpatient appointments with the same consultant. Presumably, a patient would not need to be formally advised of the consultants' fees prior to each appointment (an approach that would be quite inefficient), but it would be useful to clarify this point.

(d) The proposed remedy refers to information about which PMIs recognise a consultant. PMI recognition reflects any arrangement between the consultant and the PMI, this information is not within the knowledge or control of the hospital, which may raise difficulties in monitoring and requiring the provision of information.

6.3 The PDR suggests that, in the longer run, it would be preferable for consultants' fees to be published on both their own websites and a centralised website where fees could be compared rather than only provided in writing to patients once they have made an outpatient appointment. Spire concurs: the publication of

consultant fees for initial appointments will be important in ensuring that patients can easily access and use this information at the time of making a decision about which consultant to see.

6.4 In line with the Proposed Remedy, Spire intends to establish systems requiring, as a condition of granting practicing privileges, that all consultants provide fee information to patients using standard hospital template letters. The Proposed Remedy intends to make it the hospital operators' responsibility to enforce compliance with this requirement. Accordingly, Spire will use its best endeavours to enforce compliance (especially when their medical secretaries are located in other hospitals), but since it does not and cannot have complete control over consultants' administrative practices, it should not be held liable for individual consultants' failure to comply.

7. REMEDIES THE CC DOES NOT INTEND TO PURSUE

Remedy 2(a)

7.1 Spire agrees with the CC's conclusion that Remedy 2(a) would not be effective in addressing any alleged AEC. Spire understands that this conclusion is supported by the submissions and evidence of a broad range of industry participants who pointed to the risk of distorting competition and the complexity of implementing or enforcing such a remedy. In addition, as set out in Spire's response to the Notice of Possible Remedies, the concerns identified by the CC with respect to tying and bundling are not relevant to Spire.

Risk of distorting competition

7.2 As Spire explained in its response to the Notice of Possible Remedies, the proposed Remedy 2(a) would risk capping price rises that have no connection to network changes and would put an end to pro-competitive arrangements such as volume-based discount policies. Several other parties similarly expressed concern that the remedy would have significant unintended consequences, including the elimination of volume-based discount policies and PMI restricted network policies. [41]

7.3 Spire welcomes the CC's recognition in the PDR that volume discounts can be legitimate.[42] Volume-based discounts are the foundation for agreements between PMIs and PHPs such as corporate coverage schemes (where a PMI negotiates a discount for a particular large corporate client) and restricted networks (where a PMI seeks discounts in exchange for some degree of exclusivity).

7.4 Part of the problem with the proposed Remedy 2(a) was the uncertainty it would introduce into contracts between PHPs and PMIs. The remedy, as described in the Notice of Possible Remedies, would have allowed a PMI to negotiate a price across a PHP's entire portfolio of hospitals and then de-recognise all but the highest quality and/or highest cost hospitals undermining the basis on which the portfolio-

41 Bupa, AXA, BMI: PDR paras. 3.12, 3.15 and 3.24 respectively.

42 PDR, para. 3.54.

wide price was negotiated. Allowing PMIs to renege on volume promises that justified a given price[43] would distort negotiations between PMIs and PHPs and risk consumer detriment, for example, as a result of hospital closures.[44] The problems inherent in allowing PMIs to unilaterally alter contract terms are particularly acute given the clear evidence that the balance of power in national negotiations with Spire weighs in favour of at least the large PMIs.

7.5 These flaws in the proposed Remedy 2(a) lead to the conclusion that the remedy would not be effective, could in fact undermine competition and should not be implemented.

Complexity to implement and monitor

7.6 Spire also agrees with the submissions of other parties such as Aviva, Nuffield and the OFT that Remedy 2(a) would be very complex to implement and monitor. [45] As the CC rightly points out, "*distinguishing between an inappropriate exercise of market power and legitimate cost-reflective volume discounts in this market is likely to be complex*"[46]. This complexity and the resulting uncertainty would prevent Remedy 2(a) from being effective, even if there were a relevant AEC.

The concerns identified by the CC are not relevant to Spire

7.7 The PDR identifies continued concern about the ability of certain hospital operators to exploit local market power when negotiating terms with PMIs nationally. The proposed Remedies 2(a) and 2(b) were designed to address two specific types of conduct that PMIs had said that hospital operators engaged in:

(a) Raising, or threatening to raise, prices across all their hospitals in the event that a PMI recognised a rival on its network; and

(b) Raising, or threatening to raise, prices across all their hospitals if a PMI proposed reducing the number of hospitals it recognised in a group.[47]

7.8 As set out in Spire's response to the Notice of Possible Remedies, Spire does not have any contracts with PMIs that allow it to unilaterally raise prices for any reason. Any variation to the pricing provided for under contract has to be negotiated and agreed bilaterally. Spire is, therefore, already unable to increase its national pricing to PMIs in response to a change in a PMI's network strategy. ✂. Spire is not

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43 As noted by BMI, at para. 3.25 PDR. Ramsay similarly argued (at para. 3.45 PDR) that to insist that a hospital group's prices remained unchanged in these circumstances was unfair and unreasonable.

44 Any remedy (including 2(a)) that would increase the likelihood of a major PMI delisting one of Spire's hospitals would increase the likelihood that Spire would close that hospital.

45 PDR paras. 3.18, 3.44, and 3.49.

46 PDR, para. 3.79.

47 Competition Commission, Provisional Decision on Remedies at para 3.6.

aware of the terms of contracts between other PHPs and the PMIs, but the Proposed Remedy would have had no effect *vis-à-vis* Spire since it related to practices in which Spire does not, and could not, engage.

Remedy 2(b)

7.9 The PDR concludes that Remedy 2(b) would not be effective either, since while hospital operators would lower prices in pro-competitive areas, they would seek to raise them elsewhere and would not be deterred from doing so by the threat of entry or other factors. While Spire welcomes the conclusion that Remedy 2(b) would not be effective, there are several statements in the PDR with respect to market conditions that reflect a misunderstanding of Spire's position in the market. These statements are addressed below.

7.10 First, the PDR suggests that, if Remedy 2(b) were implemented, hospital operators would raise prices substantially above current levels at hospitals where there was little or no local competition or where it was important for a PMI to include that hospital in its network. The concern is presumably not that prices could rise above current levels, but that prices could rise above competitive levels (if local pricing were introduced, prices may well rise at hospitals facing higher local costs). Further, these statements in the PDR inaccurately reflect Spire's position in local markets.

(a) Spire's hospitals are subject to a range of competitive constraints, including from facilities in other geographic areas, outpatient and day-case providers, and the NHS (both PPUs, private provision outside PPUs and the general NHS) and, as explained in Section 8, below, Spire does not have market power.

(b) Even in areas where the CC's initial (flawed) LOCI filter identified Spire "hospitals of concern" as operating in "Single" or "Duopoly" areas, the CC's own PCA does not show a statistically significant relationship between local concentration and self-pay prices charged by Spire.

7.11 Second, as is clear from recent evidence of entry and expansion, there are no insurmountable barriers to entry in the UK, thereby further increasing the constraints Spire faces at the local level. Moreover, Remedy 3 is targeted at further lowering barriers to entry.

Price control

7.12 Spire agrees with the CC's assessment that the private healthcare industry is not a suitable market for the imposition of a price control regime. Indeed, none but one of the industry participants who commented on the Notice of Possible Remedies favoured the imposition of a price control regime.[48] As the CC correctly concludes, the cost of setting up and administering such a regime would be considerable, and the regime might well remove incentives to innovate and / or deter new entry.

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[48] PDR para. 3.91.

8. ADDITIONAL CONSIDERATIONS

Any market power has to be local

8.1 As the CC says in its PDR,[49] and in line with its PFs, evidence suggests that private healthcare is primarily a local business and that, if a hospital group were to have market power, that market power would be a result of the power it held in individual local areas.

8.2 The local focus of competitive dynamics is clear from the evidence of negotiations between hospitals and insurers. For example, ✂.

Spire does not have market power

8.3 The estimation of Spire's market power in negotiations with PMIs in the PDR is more conservative than the estimation in the PFs, but still vastly overstates Spire's position in the market. As Spire has set out in detail in its response to the PFs, Spire's explanation of competition is the only one that explains the observed market outcomes, the market evolution in the last five years and the profitability of Spire and the PHPs. To arrive at an adverse finding in respect of Spire, the PFs need to omit key evidence, ignore the outcome of the CC's own PCA and IPA analyses, and adopt a wholly flawed and error-strewn profitability methodology.

8.4 For example, the propositions underlying the conclusion in the PFs that Spire has market power in negotiations with PMIs are set out in paragraphs 6.290 to 6.292 of the PFs. These paragraphs are followed by the summary that "*on the basis of the considerations in paragraphs 6.290 to 6.292, in relation to insured patients, we therefore concluded that HCA, BMI and Spire, have market power in negotiations with PMIs arising from high concentration and an insufficiency of competitive constraints at the local level*." Each of the propositions in paragraphs 6.290 to 6.292, together with a brief explanation of their lack of applicability to Spire, are set out briefly in the table below. In each case, there are several reasons why the proposition does not apply to Spire, which are set out in Spire's response to the PFs, only some of these reasons are included in the table below by way of illustration.

Proposition	**Reasons for lack of applicability to Spire**
"*…certain characteristics of hospital portfolios, including in particular there being an insufficiency of competitive constraints on average at the local level, were associated with high levels of insured prices at the national level. We found this to be the case for*	The PFs suggest that Spire has ✂ hospitals "of concern". The evidence shows, however, that neither any PMI nor Spire has ever considered Spire to have anywhere close to ✂ hospitals facing limited local constraints. Following detailed analysis of the competitive dynamics in Leeds, conducted in the context of a divestment assessment the CC has recognised that Spire Leeds is "*sufficiently constrained by the Nuffield Leeds Hospital*."[51] The preliminary screens mis-identified Spire Leeds as a hospital of concern. Similar mis-identification of

[49] For example, PDR para. 2.69.

[50] Competition Commission, Provisional Findings at para 6.290.

[51] Competition Commission, Provisional Decision on Remedies, Appendix 2(2) at para 197.

BMI and Spire."[50]	other Spire hospitals as hospitals of concern has led to a conclusion that Spire has market power (this point is discussed further below).
"this relationship is supported by evidence from the PCA, which found a relationship between price and concentration for self-pay patients…"[52]	The PCA does not show a statistically significant causal relationship between local concentration and self-pay prices charged by Spire.
"*this relationship is supported by… evidence from the negotiations, and the planning of negotiations, between hospital operators and the larger PMIs, which showed that the position of the hospital operators in one or more local areas is important.*"[53]	Even evidence from PMIs contradicts this view with respect to Spire. For example: o "*AXA PPP also argued that although Spire … owned some solus hospitals (or hospitals that were necessary to provide an alternative to one of the other providers) it felt that, in the round, there was a balance in the relative levels of commercial leverage between Spire … and PMIs*"[54] o ✂ o "PruHealth stated also that, outside London, it had not seen evidence of hospital operators using their local position to influence pricing."[55]
"*We examined the extent of countervailing buyer power by PMIs in negotiations with hospital operators. Based on the prices paid to each hospital operator by different PMIs, including prices relatively to self-pay, we found that, similarly to self-pay patients, smaller PMIs had no countervailing buyer power and that larger PMIs had some countervailing buyer power, Bupa more than AXA PPP*."[56]	The IPA shows that Spire has not, over the reference period and relevant set of PMIs, consistently priced above hospital operators that do not have market power. The IPA also shows that, where Spire has priced above hospital operators that do not have market power, the price differential to at least one operator without market power has typically not been significant or economically meaningful. A typically insignificant price differential between Spire and PHPs found not to have market power does not provide a basis for a conclusion that Spire has market power. Relevant, material exculpatory evidence from the CC's own IPA was not reflected in the main PF report. Finally, the fact that AXA PPP considers there to be a balance in relative levels of commercial leverage between itself and Spire must imply that Spire similarly has no leverage over, at a minimum, a larger PMI such as Bupa.
"*From our profitability analysis, we concluded that BMI, HCA and Spire have, during the period under review, been earning returns substantially and persistently in excess of the cost of capital*."[57]	There are significant flaws in the methodology used to assess Spire's profitability and significant errors in the calculations. For example, Spire's capital base was understated by approximately £429 million and its return on capital employed was overstated by approximately 8 percentage points. To the extent that Spire is more profitable than other firms while its prices are not significantly or consistently higher than the prices of firms without market power must be explained by Spire's greater

52 Competition Commission, Provisional Findings at para 6.290.

53 Competition Commission, Provisional Findings at para 6.290.

54 Appendix 6.11, para 14 (citing AXA's response to the AIS at pages 3 and 20).

55 Appendix 6.11, para 14.

56 Competition Commission, Provisional Findings at para 6.291.

57 Competition Commission, Provisional Findings at para 6.292.

	efficiency and this fact is consistent with effective competition.

8.5 The incorrect assessment of Spire's position in the market and profitability result in an unsustainable assessment of consumer detriment, at least in so far as it is assessed with respect to Spire. The assessment of consumer detriment was based on: (i) a conclusion that Spire had market power, which as set out above is unsupportable; and (ii) the profitability analysis, which again, as set out above and in greater detail in Spire's response to the PFs was calculated incorrectly as regards Spire. Spire cannot comment on the assessment of consumer detriment as regards the activities of other operators, but this analysis must be reassessed as regards Spire because it is clearly inapplicable.

Spire hospitals have been mis-characterised as having market power

8.6 Spire understands that the CC used the LOCI network effect as a filter and has now "*conducted a detailed analysis of the competitive dynamics in the local area in order to come to a view on the extent to which a divestiture may be an effective and proportionate remedy to the weak competitive constraints in that area.*" As such, the proposed divestitures set out in the PDR are "*not… dependent on the LOCI measure or our identification of a number of co-owned hospitals as forming a 'cluster' but rather on an area-by-area assessment.*"[58]

8.7 At the time of publishing the PFs and Notice of Possible Remedies, the Spire Leeds hospital was identified as a "hospital of concern" and targeted for possible divestment based on the analysis undertaken up to that point. Further analysis prior to the publication of the PDR has led the CC to conclude that "*Spire Leeds Hospital is sufficiently constrained by the Nuffield Leeds Hospital*",[59] a conclusion that is supported by substantial evidence from Spire and from third parties.

8.8 As set out in Spire's response to the PFs, while the PFs suggested that Spire had ✂ hospitals "of concern", the evidence shows that neither any PMI nor Spire has ever considered Spire to have anywhere close to ✂ hospitals facing limited competitive constraints. The evidence record disclosed by the CC does not support the conclusion that Spire has ✂ hospitals of concern. The local hospital assessments prepared at the time of the PFs overlooked evidence of: the general competitive climate facing individual hospitals; competitive responses in specific areas from Spire and other operators to each other and to the general NHS; actual competition from PPUs, privately-funded NHS and the general NHS winning business away from private hospitals; the capacity of competitors; and therefore the possibility of both supply-side and PMI switching. Even evidence from PMIs of effective competition in specific local areas was disregarded.

8.9 If the other Spire "hospitals of concern" were subject to the same detailed analysis of the competitive dynamics in the local area as Spire Leeds, Spire is

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[58] Competition Commission, Provisional Decision on Remedies at para 2.67.

[59] Competition Commission, Provisional Decision on Remedies, Appendix 2(2) at para 197.

confident that the CC would similarly conclude that these hospitals are sufficiently constrained by other local competitors. A few examples are addressed briefly below, and a detailed overview of the evidence relating to each Spire hospital identified as "hospital of concern" was included in Confidential Annex 2 to Spire's response to the PFs.

(a) ✂

(b) ✂

(c) ✂

8.10 The mis-identification of Spire hospitals as "hospitals of concern" is a serious problem because Spire's ownership of "hospitals of concern" is the basis for the conclusion in the PFs that Spire has market power with respect to self-pay and PMI patients. This tenuous chain of logic and conclusion simply cannot be supported: the evidence, in fact, shows that the PFs greatly over-stated Spire's position in the market and that, in fact, Spire cannot be classified as one of the operators with market power either generally, or in negotiations with PMIs.

PMI pass-through

8.11 Spire regrets that the CC continues to assume that the PMI market is competitive and functions effectively to pass on any cost reductions to patients. Reliance on economic theory alone without substantiated reasons as to why this is the case is manifestly insufficient to discharge the CC's obligations of showing that this does or will actually happen in practice.

ANNEX 1 – PRO FORMA DISCLOSURE

The table below sets out the services or benefits which are available to consultants at the Hospital and the prices charged to the consultants for such services or benefits. These services or benefits are made available by the Hospital to all consultants with practising privileges at the Hospital and the charges represent fair market value for such services or benefits.

Service/Benefit	Charge

ANNEX 2 – CLARIFICATIONS REGARDING CONSULTANT ARRANGEMENTS

Background	Comments/Questions
<u>Clarification 1</u>: The Proposed Remedy should clarify how the term "*clinician*" should be defined.	
▪ The PDR indicates that the Proposed Remedy extends only to arrangements between "*private hospital operators*" and "*clinicians*."[60] ▪ The PDR further states that the Proposed Remedy is not intended to apply to any arrangements that "*involve only clinicians*" or arrangements between clinicians and "*other parties such as insurers, or private healthcare providers other than private hospital operators*."[61]	▪ The term "*clinician*" should include all doctors (including GPs and consultants).[62] ▪ It is unclear whether the remedy would also encompass physiotherapists and radiologists, or would apply to all referrals made by or on the advice of "medically trained professionals". This would also capture referrals made on the advice of medically trained professionals (e.g. PMI referrals on the advice of their in-house doctors). Is this intended? ▪ Spire presumes that a clinician cannot escape the scope of the remedy by forming a wholly-owned corporate entity (where services/benefits would, in theory, be provided to the corporate entity rather than to the consultant). ▪ On the other hand, if a clinician owned a minority share in a company that provided (non-clinical) services to a hospital, the CC appears to suggest that this should not fall within the scope of the Proposed Remedy. ▪ Further guidance and/or clarification would therefore be useful about where the line between these two extremes should be drawn. More specifically: in which circumstances will an entity be considered to be a "*clinician*" for purposes of the Proposed Remedy? (For example, is a clinician required to exercise "decisive influence" over the entity?) ▪ Guidance would also be helpful with respect to whether the Proposed Remedy applies to arrangements between clinicians and facilities that are wholly owned or operated by clinicians.

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60 PDR, para. 2.375.

61 PDR, para. 2.375.

62 *See, e.g.*, Provisional Findings, para. 3.55. The glossary provided in the PDR does not define the term "clinician."

Background	Comments/Questions
<u>Clarification 2</u>: The Proposed Remedy should clarify how the term "*private hospital operator*" should be defined.	
▪ The PDR indicates that the Proposed Remedy extends only to arrangements between "*private hospital operators*" and "*clinicians*."[63] ▪ The Proposed Remedy appears to apply irrespective of the level of shareholding held by a private hospital operator in a facility.	▪ For example, if a private hospital operator owned a minority stake in a facility and provided certain services to that facility, and the facility were considered to therefore fall within the definition of a "*private hospital operator*" for these purposes, would the individual shareholdings of consultants with a stake in the facility then have to be less than 3% (and disclosed on the website). How would this situation be treated by the Proposed Remedy? ▪ The definition of "*private hospital operator*" does not seem to capture operators of outpatient facilities for whom it is therefore possible to incentivise clinicians. In the interests of capturing all incentive arrangements with clinicians and to ensure a level playing field between providers, the definition of "*private hospital operator*" should also include operators of outpatient facilities. ▪ Similarly, as providers of private healthcare services, PPUs and the NHS (when providing private healthcare outside a PPU) should also be included in the definition in order to ensure a level competitive playing field. In particular, consultants should not be able to use NHS facilities free of charge for their private work. ▪ It would be useful to clarify explicitly that (based on the scope of the MIR and because NHS work carried out at private facilities is billed and paid for differently) the Proposed Remedy relates only to private, and not NHS, work.

[63] PDR, para. 2.375.

Background	Comments/Questions
<u>Clarification 3</u>: Determining the fair market value of services provided to clinicians presents certain practical difficulties. In light of these difficulties, the Proposed Remedy should provide further guidance/clarification about how fair market value should be determined.	
▪ The Proposed Remedy mandates that all services and benefits provided to clinicians by private hospitals must be at fair market value.[64]	▪ Evaluating the fair market value of services provided by Spire to the clinicians that operate in its hospitals raises certain practical difficulties. For example: o If Spire provides free car parking at a hospital to patients and other hospital staff, does any value attach to the similar right held by consultants to park for free? (Would this assessment differ if only hospital staff, but not patients, were entitled to park for free?) o How can consulting rooms in a hospital (which have no alternative use that could be used as a benchmark) be valued? o Consulting rooms are typically subject to fluctuations in demand between different days of the week and different times of day. If a hospital wishes to charge variable prices in order to manage these demand flows, is that consistent with the principle of fair market value? ▪ As a general rule of thumb, the CC could for example specify that all services priced above cost are presumed to be charged at fair market value.
<u>Clarification 4</u>: The Proposed Remedy should make clear how existing arrangements that do not comply with the Proposed Remedy should be terminated.	
▪ The CC's final Order should make clear how existing arrangements that do not comply with the Proposed Remedy should be treated.	▪ Are arrangements that do not comply with the Proposed Remedy automatically null and void? ▪ If existing arrangements with a consultant require Spire to make a payment (*e.g.*, a penalty fee) in the event that the arrangements are terminated before the end of their contractual term, is Spire required to make such a payment? If so, what constraints apply to this payment (need it represent fair market value or simply be "*reasonable*"?)

[64] PDR, paras. 2.377 and 2.379. As noted below, there is, however, no stated requirement that any payments made by hospitals to clinicians for services performed should be at fair market value payments (*see* PDR, para. 2.380).

Background	Comments/Questions
<u>Clarification 5</u>: The Proposed Remedy should make clear whether services provided by clinicians to private hospital operators should be provided at fair market value.	
▪ The CC indicates that the payments made to individual post-holders should be disclosed on a hospital's website. ▪ However, in contrast to the rules relating to services provided to clinicians by hospitals and equity arrangements, there is no stated requirement that such payments should represent fair market value.[65]	▪ It is important to clarify that services provided by clinicians to private hospitals should also be provided at fair market value in order to avoid incentives being provided through an alternative mechanism. ▪ It may be the case that any payment from a hospital to a clinician for services provided that exceeded market value would be considered a direct incentive, and therefore would be prohibited in any case under the proposed "outright ban" on such arrangements.[66] ▪ In any case, further guidance on the CC's intended approach here should be provided.
<u>Clarification 6</u>: The Proposed Remedy should clarify whether it applies to clinicians who are primarily or wholly employed by the hospital.	
▪ The Proposed Remedy does not appear to be intended to cover the "*normal*" provision of services by a consultant,[67] but rather to apply with respect to any additional services provided for remuneration (such as "*taking up a part time position*").[68]	▪ It is not clear whether the Proposed Remedy is intended to apply to clinicians who are primarily or wholly employed by the hospital (and who are effectively hospital employees being paid a salary), such as radiologists, resident medical officers, and clinicians employed to carry out Bupa health screening. ▪ Spire's firm view is that clinicians in this position should not be subject to the Proposed Remedy. In any case, further guidance should be provided on the extent to which clinicians in such a position fall within the scope of the remedy (and what factors should be taken into account in assessing whether individual clinicians fall within the scope of the Proposed Remedy or not).

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65 PDR, para. 2.380.

66 PDR, paras. 2.381-2.382.

67 PDR, footnote, 166: "*This provision is not intended to cover a situation where a hospital charges a self-pay patient or PMI a packaged fee for a procedure and then reimburses the consultant with his normal fee from the packaged fee*."

68 PDR, para. 2.380.

Background	Comments/Questions
Clarification 7: The Proposed Remedy should clarify whether it is applies to activities relating to a hospital's Medical Advisory Committee.	
▪ Every private hospital has a Medical Advisory Committee (***MAC***) comprised of consultants of all specialties offered at the hospital. ▪ The MAC determines the standards required to be met by consultants wishing to practice at the hospital, as well as the clinical governance requirements to be followed in practice. ▪ A MAC will typically meet periodically (*e.g.*, quarterly) to discuss clinical governance issues at the hospital, and the Chair of the MAC typically meets with hospital management on a more frequent basis in relation to any ongoing issues.	▪ MAC functions are voluntary. To encourage and reciprocate the provision of a valuable service to a private hospital operator, consultants serving on a hospital's MAC are compensated for their reasonable expenses and provided with benefits of a significantly lower value than the fair market value of the services provided to the hospital. ▪ It is Spire's firm view that such arrangements with MAC members should not fall within the scope of the Proposed Remedy, provided that the value of benefits provided to consultants in these circumstances is lower than the fair market value of services provided by the consultant to the hospital.
Clarification 8: The Proposed Remedy should clarify whether any legitimate distinction can be made between different consultants in relation to the provision of "services of higher value" provided by a hospital operator.	
▪ One of the requirements relating to the provision of "*services of higher value*" to consultants is that they should be made available to all consultants with practising rights at the hospital rather than being "*allocated selectively*."[69]	▪ Further guidance is necessary as to whether any legitimate distinctions can be made between consultants. More specifically, would the CC's definition of "fair market value" allow for different rates to be charged to encourage new entry and growth. For example: o If a hospital is seeking to encourage the development of a particular specialism, is it possible to offer consulting rooms at a lower price for that specialism (as compared to the price charged for a more established specialism)? If this is not possible, is there a risk of conflict with the requirement to charge fair market value (or is the price for a consulting room that the market is able to bear always considered to be the same for all specialisms)? o Is it possible to distinguish between new consultants (where the "market rate" charged for consulting rooms might be lower to encourage new entry) and more established consultants?

[69] PDR, para. 2.379.

Background	Comments/Questions
<u>Clarification 9</u>: The Proposed Remedy should clarify whether the definition of an "equity participation scheme" is only intended to cover corporate structures or whether it applies equally to "unincorporated" arrangements.	
▪ The CC indicates that the Proposed Remedy applies to "*equity participation schemes*" in which clinicians acquire an "*equity stake*" in a "*vehicle or entity created by a hospital operator*."[70] ▪ However, in some cases, co-investment arrangements with consultants can take the form of "contractual" joint ventures, in which the rights and obligations of the parties (*e.g.*, to share in the profits at a particular facility or from a particular piece of equipment) are set out in contractual arrangements between them, without a separate corporate entity being established.	▪ It is not clear from the PDR whether the definition of an "*equity participation scheme*" is intended to cover only corporate structures (such as partnerships and limited companies) or whether such "unincorporated" arrangements also fall within its scope. ▪ As a practical matter, there is no reason to exclude "unincorporated" arrangements, as restricting this part of the remedy to permit only corporate structures seems likely to result in inefficient and unnecessary incorporations (*i.e.*, consultants and private hospital operators purchasing off-the-shelf "shell" companies to enter into arrangements that could otherwise have been achieved contractually). ▪ If "unincorporated" arrangements do not qualify as an "*equity participation scheme*," further clarification and guidance is necessary about how such arrangements will be treated under the Proposed Remedy. Would such arrangements be automatically prohibited outright (as a scheme that incentivises patient referrals), or would they be assessed under the rules relating to the provision of services by consultants (*e.g.*, a 3% share of revenues would be acceptable so long as this represented fair market value)?
<u>Clarification 10</u>: The Proposed Remedy should clarify how the 3% permitted stake in an "equity participation scheme" should be measured.	
▪ The CC provides that the "*equity stake*" of any clinician with practising rights or the ability to commission tests at the facility concerned should be limited to 3%.[71] ▪ There are, however, a number of ways in which an equity interest in a corporate structure might be held (*e.g.*, different classes of share can have different voting rights or preferential distribution rights *etc*.)	▪ The CC indicates that its concerns about equity schemes relate to the circumstance in which the "*pool of rewards*" from a scheme is shared between a small number of clinicians and an individual clinician's conduct could affect the performance of the business entity.[72] ▪ It may therefore be the case that an individual's "equity stake" should be limited to 3% on any basis (*e.g.*, 3% of all shares, 3% of voting shares, 3% of dividend rights, 3% of profit distribution rights *etc*.). Spire suggests clarifying this point. ▪ The 3% permitted stake should thus apply to both direct and indirect shareholdings.

[70] PDR, para. 2.383.

[71] PDR, para. 2.391(b).

[72] PDR, para. 2.389.

Background	Comments/Questions
<u>Clarification 11</u>: The Proposed Remedy should provide further guidance around how the fair market value of a clinician stake in a pre-existing joint venture should be determined.	
▪ The CC indicates that existing joint venture arrangements that do not meet the conditions for exemption set out in the Proposed Remedy may be "*suitably amended*" within a period of six months from the date of the CC's final order arising from the inquiry.[73] ▪ One of the three conditions for new equity participation schemes is that the equity stake must be paid for by the clinician "*up front*" and at fair market value.[74] ▪ While the requirement to pay for the stake "*up front*" presumably means that payment must be made within the six-month transition period, the requirement to pay fair market value (assuming it applies) raises certain difficulties.	▪ When should fair market value be determined? Should this be based on the current value of a 3% stake or the value of a 3% stake at the time that the arrangement was originally entered into (adjusted for inflation)? ▪ The CC indicates that "*the use of a pre-set formula in a JV agreement for determining fair market value should be acceptable, provided that the formula is reasonable*."[75] Does this general principle also apply where such pre-set formula are used to bring an existing joint venture into compliance with the Proposed Remedy? In what circumstances would a pre-set formula not be considered to be "*reasonable*"?
<u>Clarification 12</u>: The Proposed Remedy should provide further guidance in relation to what could be considered an "implied" requirement to refer.	
▪ One of the three conditions for new equity participation schemes is that the acquisition of the equity stake "*must not be linked to any requirement on the clinician, <u>express or implied</u>*" to refer patients to the hospital, conduct a minimum percentage of the clinician's private practice at the hospital, practice at the hospital for a minimum period, or commit to providing a given level of throughput (on a piece of equipment).[76]	▪ For the avoidance of doubt, Spire assumes that this prohibition attaches to any circumstance in which there is a commitment or obligation to bring business to a facility in which a consultant holds an equity stake and therefore – as a formal matter – there need not be any "*link*" between the acquisition of the stake and the referral commitment or obligation. ▪ For purposes of clarity, it would be useful if the CC could provide guidance on the circumstances in which it would consider that an "*implied*" requirement to refer might exist.

[73] PDR, para. 2.391.

[74] PDR, para. 2.391(a).

[75] PDR, footnote 169.

[76] PDR, para. 2.391(c).

ANNEX 3 – CLARIFICATIONS REGARDING INFORMATION REMEDIES

Background	Comments/Questions
Issue 1: Certain indicators referred to in the Proposed Remedy are not included in patient episode data; a recommendation that the relevant organisations provide this data to the information organisation may be necessary	
▪ The PDR indicates that private healthcare providers will be required to collect and submit patient episode data to a suitable information organisation from which the latter can derive various types of performance measures at both the hospital and consultant level, including revisions rates	▪ Data on revision rates is primarily gathered and analysed by the National Joint Registry. ▪ Spire would suggest that the remedy recommend that the National Joint Registry provide this data to the information organisation.
Issue 2: Procedure-specific measures of improvements in health outcomes may not be available for all relevant procedures	
▪ The PDR indicates that private healthcare providers will be required to provide data to the information organisation from which that organisation can derive performance measures at both the hospital and consultant level including, for the ten highest-volume, or otherwise most relevant, procedures, a procedure-specific measure of improvement in health outcome	▪ The patient-reported outcome measure (PROM) programs developed by the NHS were developed based on a thorough assessment of the appropriate measures. PROMs are currently limited to hip and knee replacements in the private sector and NHS, and hernia repair and varicose vein surgery in the NHS ▪ Spire recognised the theoretical value of procedure-specific measures of improvement in health outcome, but such measures may be useless or detrimental if they cannot be designed to provide relevant and accurate information. Development of such measures is a complex undertaking and one that likely requires significant study by relevant experts. Such measures could not be developed for many procedures in a reasonable timeframe, if at all.

Background	Comments/Questions
Issue 3: NHS and private data on consultant performance are not directly comparable due to the attribution of team-wide measures to a consultant in the NHS	
▪ The Proposed Remedy would require that data submitted by the private hospital operators to the information organisation be fully comparable with that collected by the NHS to allow the information organisation to report performance measures for the whole of consultants' practices, both NHS and private, since the PDR suggests that this is the relevant basis on which to judge performance	▪ Although Spire recognises the logic behind the CC's suggestion, it poses practical difficulties because consultant performance data in the NHS and private sector is not directly comparable. In the NHS, a procedure may be undertaken by any member of a consultant's team, but will be coded to the consultant. As a result, performance measures in the NHS reflect the performance of the team, while performance measures in the private sector reflect the performance of the individual consultant.
Issue 4: The Proposed Remedy should make clear that data will be made available to any suitable data analysis provider, not only to Dr. Foster.	
▪ The PDR suggests that hospitals will be required to make data 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	▪ The drafting in the PDR suggests that Dr Foster may be the only data analysis provider who would be able to require access to the data; there may be benefits to patients if access to the data was opened to other data analysis providers who might introduce new or innovative methods of presenting the most relevant data to patients, provided that appropriate data protection rules are in place. ▪ A sensible approach would seem to be to stipulate that PHIN could license access to its database on terms and conditions established to protect patient data and to ensure appropriate use of that data.
Issue 5: The Proposed Remedy should make clear that publication of consultant fees would not be limited to a single centralised website	
▪ The PDR suggests that, in the longer run, it would be preferable for consultants' fees to be published on both their own websites and a centralised website where fees could be compared rather than only provided in writing to patients once they have made an outpatient appointment	▪ The description of the Proposed Remedy in the PDR may suggest that the publication of consultant fees would be limited to a single centralised website. Opening this opportunity to other independent organisations seeking to offer a service to patients would introduce competition in the provision of information and could lead to the introduction of new and innovative information services for patients.