

THE LONDON CLINIC
COMPETITION COMMISSION PRIVATE HEALTHCARE MARKET INVESTIGATION
RESPONSE TO PROVISIONAL DECISION ON REMEDIES

Introduction and General Comments

1. The London Clinic (the "Clinic") welcomes this opportunity to comment on the Provisional Decision on Remedies ("PDR") published by the Competition Commission ("CC") on 16 January 2014.
2. The Clinic welcomes the CC's provisional findings and is broadly supportive of the package of remedies that has been proposed, subject to the comments below.
3. The Clinic's main concern is that the proposed remedy on clinician incentive schemes is insufficiently clear and on one interpretation would be ineffective in addressing the identified distortion of patient referrals and choices. Accordingly, the Clinic urges the CC to revisit this remedy.
4. The Clinic considers that it is important that the remedies are considered as a package since none of the proposed remedies alone would be able to address the adverse effects on competition ("AEC") identified.
5. The Clinic sets out below its comments on the proposed remedies, as they would apply in the central London market. The Clinic has no comments on the remedies the CC does not intend to pursue.

Divestiture (Remedy 1)

6. As noted in the Clinic's response to the Provisional Findings and Notice of Possible Remedies, the Clinic considers that, given the CC's provisional finding of high barriers to entry and weak competitive constraints in the central London market, divestment of an appropriately structured package by HCA would in principle be an effective, reasonable and proportionate remedy.
7. The Clinic considers that, on balance, the proposed divestiture of London Bridge Hospital and Princess Grace Hospital by HCA is a suitable divestment package.
8. However, the Clinic has a continuing concern that the divestment remedy does not address the issue of HCA's dominant position in oncology in the central London market, which is entrenched by HCA's ownership of LOC. Remedy 4, as set out in the PDR, does not adequately address the AEC resulting from equity stakes held by consultants practising at LOC. Unless Remedy 4 is amended as suggested below, the Clinic considers that the CC should consider requiring divestment of LOC, in addition to London Bridge and Princess Grace.

9. In addition, the Clinic considers that future acquisitions in central London by private hospital operators with significant market power should be subject to the same competition test as proposed in respect of PPUs in Remedy 3, i.e. parties to future acquisitions would be required to notify all such arrangements, and acquisitions which failed the suggested competition test would be prohibited. This remedy would ensure that transactions structured to avoid the merger control regime would still be subject to competition review.

PPU review (Remedy 3)

10. The Clinic supports the proposed remedy that anticipated transactions between NHS Trusts and private hospital operators for the operation of a PPU be evaluated on a case by case basis on their merits by the CMA.
11. The Clinic considers that the proposed competition test to be effective and not overly costly to operate¹. The Clinic would support a "safe harbour" for benign transactions provided that arrangements entered into by hospitals with significant market power on any market are always subject to competition scrutiny.
12. The Clinic considers that, for the avoidance of doubt, the CC should make clear that the proposed competition test would apply not just to tenders for entirely new PPUs, but would also apply to the expansion or renewal of arrangements for existing PPUs, including the transfer in of additional services from other hospitals.

Incentive schemes (Remedy 4)

13. The Clinic strongly agrees with the provisional conclusion of the CC that incentive schemes operated by private hospitals and equity ownership by consultants of private health facilities affect consultant behaviour and give rise to harmful effects on competition (PDR, paragraph 2.267).
14. In the Provisional Findings and Notice on Possible Remedies, the CC proposed prohibiting hospital operators from offering to consultants any incentives in cash or kind which are "intended to or have the effect of" encouraging consultants to refer patients to or treat them at its hospitals. The Clinic strongly agrees with this position.
15. However, the Clinic is concerned that the remedy as described in the PDR appears to have undergone a shift in language which renders the proposed remedy unclear, and, on one analysis, dilutes the effect of the remedy and does not reflect the comments of third parties.

¹ Indeed, the CC appears to conclude (PDR, paragraphs 2.261- 2.263) that the costs on the parties and the CMA of this remedy would be low.

The Clinic's understanding of Remedy 4

16. It is the Clinic's understanding that the CC proposes:
- 16.1 to prohibit "direct incentives" (defined as those which "link, implicitly or explicitly, the value of the rewards provided to a clinician to the value of that individual clinician's conduct to the hospital operator" (PDR paragraph 2.366));
- 16.2 to permit "indirect incentives" (defined 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 paragraph 2.368)), subject to certain caveats.
- 16.3 There appears to be four categories of "indirect incentives" identified by the CC: "services of low value" (paragraph 2.376), "services of higher value" (paragraph 2.378), "schemes which incentivise patient referrals" (paragraph 2.381) and equity participation schemes (paragraph 2.383). These indirect incentives would be permitted subject to: services of low value (below the value of £500 a year) being disclosed on the hospital's website (paragraph 2.377); services of a higher value being charged to clinicians at a fair market value, available to all clinicians with practicing rights at the hospital and disclosed on the hospital operator's website with the market value imputed (paragraph 2.379); and, for equity participation schemes, subject to the conditions set out in paragraph 2.391.
- 16.4 The Clinic understands that "schemes which incentivise patient referrals" (paragraph 2.381) would be prohibited outright. This is based on the CC's comments in paragraph 2.382 that "any scheme operated by a private hospital operator, whether contractual or not, which provided an inducement to, or created an obligation on, a clinician to treat or refer patients for tests at its hospital or hospitals should be prohibited outright". This would include arrangements caveated with express obligations to refer only in the patient's best interests etc. It appears that the CC has concluded that an "outright ban would be the simplest and most effective way of solving the competition problems arising from these arrangements".
17. If the Clinic's understanding of what is proposed is correct, the Clinic supports the remedy, but urges the CC to clarify the position on prohibited incentives falling into the category of "schemes" as described above and in PDR paragraph 2.381 and 2.382. In the Clinic's view, it would be simplest to revert to the language of the PF and Notice on Possible Remedies, which referred to an outright ban on incentives "intended or having the effect of" influencing referrals. This would represent an effective and comprehensive remedy to address the AEC identified by the CC, being, the "distortion of referral decisions to particular hospitals and distortion of patient choice of diagnosis and treatment options" (PDR, paragraph 1.11).

The Clinic is concerned that a narrower construction of the prohibition of clinician incentives would be ineffective in addressing the AEC

18. The Clinic is concerned that it may be the intention of the CC that the scope of the prohibition should be narrowly construed to include only "direct" clinician incentives (as defined) whilst permitting all "indirect" incentives subject only to the transparency requirements², and, in the case of equity participation, the conditions in paragraph 2.391.
19. A prohibition of only "direct" incentives would be ineffective since the AEC in the central London market is not caused by "direct" incentives. As the CC itself notes "large hospital groups abandoned the more straightforward cash-based payments to doctors in 2011 and 2012" (PDR, paragraph 2.400) and the GMC has already banned these direct incentives. "Direct" incentives are not the problem.
20. The AEC in the central London market is caused by agreements entered into by HCA [BUSINESS SECRETS]
21. [BUSINESS SECRETS]
22. Unless the proposed prohibition covers the all consultancy agreements, arrangements or schemes which have the effect of influencing clinician referrals to private hospitals, it would be ineffective in addressing the AEC in the central London market.

The Clinic considers that the scope of the prohibition on clinician incentives therefore requires clarification

23. [BUSINESS SECRETS] However, given the potential for conflicting constructions of the scope of the prohibition as described in the PDR, the Clinic considers that it is necessary to revise the description of the prohibition.
24. The Clinic considers that the simplest, effective remedy would be that all incentive arrangements should be prohibited, including in cash or in kind incentives, which are intended to or have the effect of influencing referrals, and whether or not the arrangement states that there is no obligation to refer or that referrals should be made in the patient's best interests only. In order to

² In the Clinic's response to the Notice of Possible Remedies, the Clinic noted that if a prohibition on incentives was considered impractical or if it extended only to certain forms of incentive, then the Clinic would support a transparency based remedy. However, the Clinic does not consider that a broader prohibition than that proposed (i.e. one which captured indirect incentives) to be impractical and CC has not shown this. In addition, the Clinic has given further consideration to the transparency aspects of the proposed remedy and considers that they will also not be sufficient to remedy effectively the distortion of patient choice.

achieve a clear and effective remedy, the language of "direct and indirect" should be dropped, with the focus instead on an analysis of whether the arrangement was intended to or had the effect of influencing referrals.

25. The distinction between "direct" and "indirect" incentives is unhelpful and, HCA aside, there is almost no support for this distinction in the comments of third parties: Bupa, AXA PPP, Aviva, PruHealth, the Clinic, Ramsay and Nuffield all express support for prohibiting **all** incentives which influence referrals.
26. If the language of "direct and indirect" was dropped in favour of a straight prohibition of arrangements intended to or having the effect of influencing referrals, the Clinic would then support an exemption for the provision of low value services, subject to disclosure as proposed; and an exemption for the provision of services or facilities of higher value (for example, consulting rooms or secretarial/administrative support) at fair market value, as proposed.

The Clinic retains concerns about the proposed transparency measures

27. Unless all clinician incentives which have the intention or effect of influencing referrals are prohibited as suggested above, the proposed transparency measures could even worsen the identified AEC, by effectively broadcasting to consultants the fees available from certain hospitals and creating an arms race in which consultants would demand a matched or better offer from other hospitals, resulting in the hospital groups with the deepest pockets having a significant advantage in attracting consultants. These fees would ultimately be paid for by consumers, either as self pay patients or beneficiaries of PMI.
28. In order to be effective, the Clinic considers that disclosure of permitted incentives (low value service and higher value services or facilities at market rates, for short duration) should be made by private hospitals on their respective websites and by the consultant at the point of referral, either by prominent display or by letter/leaflet provided to the patient.

The Clinic considers that the proposed remedy on equity participation would not be comprehensive and requires revision

29. The Clinic considers that the proposed remedy would not be comprehensive and that the CC should permit equity participation by consultants (if at all) only if the participation falls below a de minimis exemption expressed by reference to value (as well as or instead of the percentage interest.) The proposed remedy caps equity participation at 3% but even a stake of an individual clinician of 3%, could still represent a significant financial investment. [BUSINESS SECRETS]

Conclusions on Remedy 4

30. In summary, the Clinic considers that the CC should clarify the scope of the prohibition on clinician incentives. In order to be effective, the prohibition should cover all schemes or agreements which are intended to influence or have the effect of influencing clinician referrals to private hospitals, as described above. The distinction between "direct" and "indirect" incentives should be dropped.
31. The transparency remedy for permitted higher value arrangements should be amended, as described in paragraph 28 above.
32. All equity participations should be prohibited, subject to a de minimis exemption for equity stakes of low value set by reference to a monetary value as well as or instead of the percentage interest.