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FIPO
federation of independent practitioner organisations

PRIVATE HEALTHCARE MARKET INVESTIGATION

Our Reply to the Provisional Decision on Remedies

February 2014

1. Introduction

1.1. The Federation of Independent Practitioner Organisations ("FIPO") has carefully considered the Provisional Decision on Remedies (the January PDR Report).

1.2. In Part I we recap succinctly why certain aspects of the remedies put forward could address the AEC identified, and why others will be ineffective. We have fewer concerns with Remedy 4 (incentives) than we have with Remedies 5 and 7 and, crucially, with Remedy 6. As remedies 6, 5 and 7 are required to work together, we are concerned that ineffectiveness of Remedy 6 would make it not possible for Remedies 5 and 7 to work too. So we will first briefly analyse again the ineffectiveness of Remedy 6, followed by Remedies 5 and 7, and finally Remedy 4.

1.3. We are not dealing expressly with the divestiture remedy which has clearly taken up the majority of time and resources at the CC. From a consultants' perspective, and from a medical perspective, it is always disruptive to find that the owner of a hospital is changing, especially if, as seems the case in the current financial environment, the new owners of the divested hospitals should happen to be equity houses and investment funds with little specific knowledge or major interest in healthcare, or of the medical profession.

1.4. In Part II we highlight our serious concerns held about the legality of this process of investigation.

PART I

2. REMEDY 6 – INFORMATION ON FEES

- **Remedy 6 is ineffective**:
  - Patients are not able to "shop around" for their chosen consultants and are often prevented from seeing their consultant of choice even when willing to make co-payments; and
  - Consultants are not able to set their fees – they are often de-recognised on the basis of fees or contractually obliged to charge what the PMIs set.

- **Remedy 6 imposes obligations on consultants to remind patients to check their policie**s. The PMIs should keep their policyholders informed. By the time a consultant sees a policyholder, the policyholder will have obtained pre-authorisation. Policyholders need information upfront.

- **Failure to address the consultant's concerns on Remedy 6 has knock-on effects of Remedies 5 and 7**: by the time information on quality becomes available there would be no freedom for consultants to set their own fees.

2.1. The CC's proposed Remedy 6 mandates "*an order to private hospitals to require, as a condition of granting practising privileges, that (all) consultants provide fee information to patients using standard* letter *templates provided by the hospital*"….and that "*Hospital operators would be responsible for ensuring that consultants complied with this requirement*" (paragraph 2.522 of the January PDR Report). The fee information is also to be published on the hospital and consultants' own websites and on the PHIN website, from 2016.

2.2. We are not at present entirely clear about whether consultants will be able to publish a range of fees. We feel that the obligation to publish should relate to a range of consultation fees for any individual consultant because, as FIPO has previously stated, the

consultation may be a brief encounter for a simple problem or a long encounter (for example with a cancer patient) with various follow-up discussions with colleagues in team meetings. If a standard consultation fee is applicable to all then in the first case the patient may be aggrieved to receive a substantial fee for a short consultation whilst in the latter the consultant will not be recompensed appropriately for the extra time he must expend in the patients' interest.

2.3. According to paragraph 2.493, *"the proposed Remedy 6 addresses the AEC identified in our provisional findings by increasing patients' awareness of the fees that they are likely to incur in seeking private treatment, whether covered by insurance or self-pay, and thereby* ***ensure that patients are able to make effective choices between consultants.*** *As a result,* ***when combined with additional information on consultant quality****, this remedy will allow patients to choose consultants that offer the best value healthcare, stimulating competition between consultants to attract patients."* In addition the CC adds at paragraph 2.517, *"the principal aim of the CC in requiring consultants to provide additional information on their fees is to* ***stimulate competition on price between consultants by facilitating shopping around by patients****."* (emphasis added).

2.4. For the reasons that we have explained throughout (the CC is referred in particular to Section 4 of our Reply to the PFR) Remedy 6 will be ineffective to address the AEC identified. We believe that the CC has correctly identified the issue from the start, as it had initially expressed a view that patients should be allowed to top up (see paragraph 116 of the AIS, and paragraph 2.19 below). ✂[1]. We discuss the implications of a failure to consider conscientiously the submissions made in the course of a consultation in Part II (paragraph 8).

2.5. To recap, we submitted that to be effective Remedy 6 necessarily had four parts (paragraph 4.8 of our Reply to the PFR) as mentioned below. We note that the views of FIPO are summarised in five lines at paragraph 2.512 of the January PDR Report. According to the CC, FIPO argued that "*consultants should be allowed* ***to set their fees at whichever level they saw fit****, with patients able to "top-up" if their insurance policy would not cover the full cost*" (emphasis added).

[1] ✂.

2.6. We note with concern the somewhat disparaging language which implies extortionate behaviour on the part of the consultants. We have never said that consultants should set the fees at *whichever level they saw fit*. In fact, the CC should know that FIPO has consistently made the point that consultants have historically been sensitive to market forces, PMI benefits and the personal financial circumstances of their patients (and thus will sometimes waive part or all of their fees in certain situations). Of course, not surprisingly, patients would always prefer to go to a consultant that does not charge top ups, other things being equal, and consultants know this. Those consultants who have the most experience and undertake the more complicated procedures must be able to charge in accordance with their expertise and to reflect the difficulty of the treatment, otherwise there is no competitive market.

2.7. ✂.

2.8. The four necessary parts of Remedy 6 that we identified were:

I. *Remedy 6(1) – the "any willing provider" principle, which allows policyholders to decide on the way in which they use the benefits that they are entitled to under their policies, paying a shortfall, if necessary, on the higher fees which consultants have been allowed to set themselves;*

II. *Remedy 6(2) – a clear obligation on PMIs not to deregister consultants on the basis that consultants charge in excess of the fees that the PMIs are willing to reimburse their policyholders;*

III. *Remedy 6(3) – a clear statement that a fee cap cannot be imposed as a condition for recognition (as a condition for entry into the private healthcare market) on new consultants; and*

IV. ***Remedy 6(4) – publication of fees by consultants***

Fee assured arrangements and Remedy 6

2.9. We asked the question in paragraph 1.5 our Reply to the PFR: unless consultants can set their own fees, what is the point of this remedy? ✂.[2] As we iterated in paragraph 4.6 of our Reply to the PFR, without freedom to charge fees, competition on fees obviously cannot occur. If ✂.

2.10. ✂.

Top-up fees and Remedy 6

2.11. The CC has not taken a clear stance on the issue of top-ups, shortfalls and co-payments which consultants believe is crucial to the very survival of the private healthcare sector.

2.12. A global search of the January PDR Report reveals:

2.12.1. Three instances where the terms "top-up" or "top-ups" are considered, namely: in paragraph 2.510, relating the views of the IDF that consultants should be free to compete on fees; in paragraph 2.512, the five lines relating the views of FIPO mentioned above and in paragraph 2.532, where the CC makes a statement about the fact that patients will benefit from the publication of consultant fees through lower top-ups (and shortfalls and co-payments). Paragraph 2.532 will be considered below at paragraph 2.47.

2.12.2. Shortfalls are mentioned: in the same paragraph 2.510, relating the views of IDF that patients should not be left with **unexpected** shortfalls, a view that is also shared by FIPO; in paragraph 2.530 (emphasis on patients being able to shop around and preventing the occurrence of unexpected shortfalls) and in paragraph 2.501, relating the views of PruHealth that potential shortfalls of anaesthetists, pathologists and radiologists should be related to the patient by the principal practitioner[3], although in practice this may be very difficult for the principal practitioner to do.

[2] ✂.

[3] As explained, with ever reducing benefits, it is very difficult for consultants to provide this information (paragraph 4.24-4.25 of our reply to the AIS).

2.13. Co-payments are mentioned in footnote 52: "*We include insured patients in this context since they are often liable for some portion of the costs of their treatment via excesses on their policies, as well as, in some cases, co-payments. As a result, they directly fund part of their treatment even when covered by insurance*". The CC correctly identifies that insured patients directly fund part of their treatment through excesses. The CC also understands that co-payments are becoming the exception rather than the rule ("*in some cases*"). ✂.

2.14. Co-payments are then mentioned in paragraph 2.531, where the CC states:

> *We recognize that many patients, particularly those with medical insurance,* ***may not choose*** *to 'shop around' even if given the information with which to do so. However, we consider that for this remedy to be effective, it is only necessary for a relatively small but significant proportion of private patients to do so. The survey undertaken by GfK for the CC indicated that 29 per cent of patients cited* ***whether or not their PMI would cover a consultant's fees***[4] *to be an important reason for choosing a particular consultant. In addition,* ***10 per cent of patients surveyed indicated that they would be prepared to travel further for a lower-cost consultant or a lower-cost hospital.*** *This suggests that a* ***reasonable proportion of patients are price-sensitive, at least to the extent that they may be required to make co-payments*** *and hence are likely to use this information to shop around. Furthermore, insured patients, if provided with consultant fee information suggested, would be better placed to determine the extent of their policy coverage as early as possible in the process and make choices in terms* ***whether to claim on their policy and/or pay any additional fees not reimbursed by their insurer****.* (emphasis added)

2.15. In this paragraph, the CC identifies the issue quite clearly. If patients are required to make co-payments, then information on fees (and quality – the CC is correct in linking the issue of fees with the issue of quality in remedies 5 and 7, see below) will result in a competitive market, a result which the consultants would welcome as FIPO has explained all along (paragraph A.13 & B.38 of our Reply to the IS; paragraph 5.17 of our Reply to the AIS; and paragraph 1.1 of our Reply to the PFR).

[4] This refers to slide 32 of the GfK survey of patients, reproduced for ease of reference, in Appendix 5

2.16. ✂. What the question does not address then, and therefore the survey does not tell us, is whether the patients may be happy to top-up, in order to see a consultant whom they believe has the relevant qualifications, and expertise. Indeed, 38% would choose a particular consultant based on clinical expertise.

2.17. ✂. If patients cannot shop around, there would be no "relatively small but significant proportion of patients" to do so and therefore by the very words of the CC in paragraph 2.531, the remedy will not be effective.

2.18. Equally, the ***10 per cent of patients surveyed indicated that they would be prepared to travel further for a lower-cost consultant or a lower-cost hospital***, must be self-pay patients because the hospital bill is always settled by the insurer. If a hospital is not recognised, the insurer will not accept the claim at preauthorisation.

2.19. With all this, we appreciate that the CC understands the issues ✂ and therefore, there is no need for us to repeat all that we have said before. In the AIS the following statement highlighted the CC's view that top-ups could be beneficial in facilitating patient choice: At paragraph 116 of the AIS, the CC reported: *"Whilst we appreciate that unexpected costs are unwelcome to patients,* ***it is not evident to us that patients are disadvantaged by top-up fees*** *if they know about them in advance and if this would allow them to choose the consultant they prefer. Allowing such fees might provide greater patient choice"*. At paragraph 116 of the AIS: *"Our current thinking is that the buyer power of Bupa, or of Bupa and Axa-PPP together, restricts patient choice in the market for consultants through the prevention of 'top-up' fees."*

2.20. The issue has not been properly considered since. ✂

✂

2.21. ✂

2.22. Individual consultants have also written to the CC to highlight this issue. As FIPO pointed out previously, associations of doctors and consultant are able to aggregate the view of a

party, namely the consultant, whose views have not been properly considered yet (see Part II paragraph 8).

Information asymmetry between the policyholders and the PMIs and Remedy 6

2.23. Not only Remedy 6 imposes wide ranging obligations on consultants to publish their fees. It also imposes obligations on consultants in relation to the policies that their patients may hold.

2.24. The CC correctly recognises the importance of keeping policyholders informed and at paragraph 2.468, concerning quality, it states:

In order to facilitate the dissemination of quality information to patients, we will require that the PMIs include standard wording in the correspondence sent to customers on taking out or renewing a private medical insurance policy informing them that they will be able to obtain quality information on consultants and hospitals from the website of the information organization. In addition, patients should be directed to this website when they call to obtain pre-authorization for treatment and whenever advising a policyholder on potential providers.

2.25. ✂.[5]

2.26. If the fees charged by consultants are in the majority or in the totality paid to policyholders in the form of benefits received under a medical policy, then there is an obvious link between giving patients information on consultants' fees as mandated by Remedy 6 and giving policyholders information about the benefits that their insurers will provide. Insured patients lacking this information cannot "*determine the extent of their policy coverage*" early on in the process (in most cases they cannot "*make choices in terms [of] whether to claim on their policy and/or pay any additional fees not reimbursed by their insurer*" either (see paragraph 2.531 of the January PDR)).

2.27. ✂.

[5] ✂

2.28. For the avoidance of doubt, what we advocated was nothing as wide ranging or onerous as the collection of information on quality and consultants' fees that the CC will mandate through PHIN. ✂

2.29. ✂.

Lack of obligations on insurers and Remedy 6

2.30. ✂.

2.31. Under Remedy 6, the onus to remind policyholders about their policies is mostly on the consultants, which appears to be illogical. Indeed consultants cannot provide meaningful information, given that the insurers have all the information about their products, and given the wide ranging and variable nature of these policies. So these obligations on consultants are too general to be of real impact.

2.32. For example the onus is being put on consultants to remind the patients about their insurance, in "*(d) a note encouraging insured patients to check the terms of their policy with their insurer, with particular reference to the level of outpatient cover they have*" (paragraph 2.523). First, at the time a consultant is in a position to remind patients of their policies, the patient has in most cases already obtained pre-authorisation. Secondly, ✂, that many policies have a global annual amount for outpatient investigations and consultations together and Bupa reminds consultants regularly that they need to take this into account when they charge outpatient fees. Thirdly, the CC should also consider what the impact would be of this statement on patients who are not allowed to make a co-payment. We make this point again in relation to top-ups, at paragraph 3.9 below.

2.33. Further, in paragraph 2.523, the CC states that the consultant should provide the patient with "*(c) a list of all insurers which recognize* (sic) *the consultants*". This is an unnecessary requirement because if the patient has obtained pre-authorisation (which is required before the patient sees the consultant), then the consultant is clearly recognised by the insurer. Failure to be recognised by any one large insurer spells the end of a consultant's career. Even de-recognition by a small insurer will have this impact on the market for recognition of consultants (each PMI is dominant when it comes to consultants'

recognition). The impact has nothing to do with the market share of a PMI on the market for the sale of policies to policyholders. So a consultant is either recognised by all insurers, or is not able to function fully in private practice. This is why recognition by a PMI is a condition of entry in this marketplace, a point that has been ignored.

2.34. To be fair, there is the following mention in footnote 198: *we note that there are several means by which […] competition may be stimulated, including by the involvement of PMIs, which* ***may choose to take a differential approach to recognition****, reimbursement and/or* ***the direction of patients towards/away from consultants*** *according to their performance.*

2.35. This footnote is unclear to us.

2.36. ✂. Generally, even when information on quality is available, the (medical) staff in a PMI who are allowed to direct patients away from the consultant that they (having access themselves to information on quality) choose (and that the GP does not recommend,) will need to be properly accountable to the GMC and liable in negligence for their actions.

2.37. ✂. This is what the consultants are experiencing now, which they have attempted to explain to the CC time and again. With respect, it is illogical to make the link between fees and quality when it comes to imposing obligations on consultants, and to fail to make the link when it comes to the PMIs.

2.38. ✂.

2.39. At present, the approach to recognition of consultants is based on objective criteria dictating that doctors with a certain number of years of studying and a particularly difficult training should be allowed to operate in private practice if they meet certain requisites. This is consistent with the case law of the European Courts on criteria for entry into a profession, as FIPO pointed out in the past (paragraph A3.28 of Appendix 3 of our Reply to the PFR). If there are alternative routes to consultant recognition, the CC must identify them.

2.40. It follows that, if footnote 198 is all the CC has to say about these issues, then the medical profession cannot live with the statements in footnote 198, for reasons ✂

2.41. There is then the issue of changing terms of a policy mid-way through the contract with the policyholders. FIPO has attracted the CC's attention to this before (paragraph A.37-A.39 of our Reply to the PFR). ✂.

2.42. ✂.

2.43. ✂[6] ✂.

2.44. Those unable to obtain ✂. In the context of the discussion about the CC imposing Remedy 5, Bupa noted its "*concerns about the practicality of the remedy noting that **it shifted the responsibility and costs on to the NHS, and therefore on to taxpayers**, rather than private providers. Given existing resource constraints on the NHS and the current wave of reforms, this may mean that a significant period of time elapsed before private patients could benefit from improved information"* (paragraph 2.414 PDR). We agree with Bupa here. Given existing resource concerns on the NHS, shifting responsibility and costs for treatment on the taxpayers is far from ideal. We pointed this out before (paragraph A1.59 (Appendix 1) of our Reply to the PFR.

2.45. In the PFR the CC claimed that this issue of changing terms without the policyholders' knowledge was one for the FOS, and then said:

"*Whilst outside of our terms of reference, it is in relation to this issue that we received the most complaints from policyholders. It is clearly important that policyholders understand the terms of their policies at purchase and renewal. <u>This includes being made aware and fully informed about changes to reimbursement rates and the recognition of consultants which will have a direct impact on the nature of and value of benefits available under their policies</u> (see Appendix 7.4 on information availability on PMIs*)."

[6] ✂.

2.46. ✂. They may not know or they may feel too powerless to start complaining to the FOS. We believe that this is a fundamental and systemic issue and to leave it open means that the CC is not addressing the AEC identified (as explained above in paragraph 2.4).

Pass through of benefits to consumers: why this won't happen under Remedy 6

2.47. According to paragraph 2.532 of the January PDR Report:

> *"The two principal benefits that we foresee resulting from this remedy [Remedy 6] are competition among consultants on the basis of price and the avoidance of unexpected costs for patients. In the case of the former, we note that total specialist fees charged for treating private patients in the UK were £1,585 million in 2011.279 Although it is not possible to quantify what proportion of this cost may be* ***saved by patients*** *as a result of increased competition between consultants, even a 2 per cent average decline in prices is equivalent to a £31.7 million decline in costs annually,* ***some of which will be saved*** *directly by patients, via lower shortfalls, top-ups and/or co-payments, and* ***some by the PMIs****, which we would expect to be passed through to patients in lower insurance premiums. While the extent to which PMIs would pass through lower costs will depend on the level of competition in the insurance market economic theory suggests that this will range from full to partial depending on the nature of competition providing private medical insurance."*

2.48. ✂. We submit that it is not open to the CC to make statements such as the statement above without any proper analysis and without showing the evidence for such statements.[7] Further, the CC has failed to engage with the consultants on this issue.

2.49. ✂.

2.50. ✂[8]. ✂.

[7] We note with approval the mention in footnote 18 of the Tesco v Competition Commission 2009 CAT case. "*The more important a particular factor seems to be in the overall proportionality assessment… the more detailed or deeper the investigation of the factor in question may need to be*". There is no doubt that the CC so far has based its own conclusions on the PMIs' action on an assumption which is rather crucial and not at all investigated.

[8] ✂

2.51. ✂[9] ✂[10] ✂[11] ✂[12] ✂This ensures that medical insurance companies spend at least 80% of the money they take in on premiums on health care and quality improvement activities instead of administrative, overhead, and marketing costs.

2.52. FIPO concludes that the proposed Remedy 6, in the absence of a remedy to ensure that existing consultants cannot be derecognised if they wish to set their own fees (and new entrants can never in any event set their own fees will not address the AEC) and that patients can select their consultants of choice, will be ineffective. It will not *"**ensure that patients are able to make effective choices between consultants"*** *or* ***"stimulate competition on price between consultants by facilitating shopping around by patients"***. Further, at this stage of the investigation, FIPO concludes that the CC has ignored the main concerns of the consultants.

[9] ✂.
[10] ✂.
[11] ✂
[12] ✂.

3. REMEDIES 5 AND 7 – THE "INFORMATION REMEDIES"

- Quality information based on standardised codes towards the NHS coding standards is the right way forward
- We are supportive of PHIN as the organisation to publish and collect the information.
- Remedy 5 and 7 are ineffective if patients and GPs cannot use the quality information provided to see a consultant of choice.
- The remedies can have serious unintended consequences for consultants who practice outside hospitals, if they are to be excluded from the system.
- ✂.

3.1. Remedy 5 related to a recommendation to the health departments of Scotland, Wales and Northern Ireland[13] to publish consultant performance indicators across the same or equivalent range as the NHS England scheme. Remedy 7 proposed a requirement that all private acute hospitals in the UK would collect HES equivalent and PROMs data for private patients and for arrangements to be made to publish this to consumers.

3.2. The CC has taken the approach of addressing both consultant and hospital quality together in a single remedy which requires private hospital operators with UK turnover of £5 million or more to provide patient episode data for all patients treated at its facilities to a suitable information organization (most likely an adapted version of PHIN). In the CC's words (paragraph 2.463 of the January PDR) "*We propose, therefore, to address both consultant and hospital quality via a single remedy which requires private hospital operators to provide information in an appropriate format to a suitable information organization for publication to patients*". We respectfully ask the CC about the effectiveness of this remedy to capture information about consultants who operate in

[13] The CC did not consider the geographic market definition. It is our understanding that there is relatively limited provision of private healthcare in each of the three nations mentioned.

private practice but not in hospital groups. Are these consultants to be totally outside the system? What would be the consequences of this remedy on their practice?

Standardisation of Codes and the Role of PHIN

3.3. The CC has recognised a number of important facts on standardisation and the need for a full involvement of PHIN in collating information on quality.

3.4. The CC recognised correctly that a move away from CCSD standards to OPCS is necessary and we are pleased to note that this **standardisation of codes towards the NHS coding** standard will be mandated by the CC. FIPO also welcomes the suggestion in the CC's January PDR Report to "*require the insurers to adapt their IT and billing systems to use OPCS coding, allowing the private hospitals to submit invoices with a single procedure code*", although we consider that this surely can be achieved considerably sooner that by April 2019 (paragraph 2.467). We consider that five years adapting IT and billing systems is a disproportionately long time especially compared to the timeframe for collection of (extremely complex) information on quality. Be that as it may, as we noted in our Reply to the PFR (at paragraph 1.7): "*Standardisation of information under Remedy 7 must include the PMIs. In a well-functioning competitive market, if policyholders were able to switch policy (not feasible for the individual) and standardised information about policies would be published and be easily comparable, both as regards the costs of treatment and the benefits payable by the different insurance providers, a growing body of data would be available and patients could use the information to shop around and choose not only the best (in their own view) consultant, treatment and hospital, but also the best insurance policy*.".

3.5. We have been and continue to be supportive of **PHIN** throughout the investigation and have highlighted to the CC that we would be willing to offer our support to PHIN as the leader of this initiative and we have and will continue to work with PHIN to co-ordinate information on consultants. Provided some measures are taken to ensure the independence of PHIN, such as the co-funding by hospital groups and PMIs, and the appointment of a board as envisaged, we do not envisage a body better placed than PHIN to marshal and disseminate data on quality.

3.6. We are pleased to note the **requirement on PMIs to inform policyholders of information available** and welcome the CC's proposal at paragraph 2.468 of the January PDR Report to require that "*the PMIs include standard wording in the correspondence sent to customers on taking out or renewing a private medical insurance policy informing them that they will be able to obtain quality information on consultants and hospitals from the website of the information organization*." The additional requirement that "*patients should be directed to this website when they call to obtain pre-authorization for treatment and whenever advising a policyholder on potential providers*", is important to counter the problem of misdirection of patients and we are fully in support of this. Of course, it will be important to see the details of the remedy imposed. ✂.

Quality and fees

3.7. We remain very supportive of the need for the medical profession as a whole to gather information on quality, to guide better treatment and outcomes, in the interest of patients. Indeed, recently the Economist wrote an article about this very topic, which is of relevance to the medical practitioners. This is reproduced in Appendix 3 for information.

3.8. We wish to point out at the outset that the remedies are designed to work together as a whole, so that, as the CC recognises, information on fees without information on quality would not work, and vice-versa. We agree that proper information on fees (to patients who are allowed to top up) would stimulate competition "to choose consultants that offer the best value healthcare", if combined with information on quality (paragraph 2.493). We would like to point out that in relation to the new quality data that PHIN will produce, it must be logical that patients (in the light of the greater information on quality which they would now have) will want to discuss this with their GP who can advise and assist them to make an informed choice. This point is made by the CC at paragraph 2.479 of the January PDR Report. There is no point identifying the scope for better GP referrals that access to quality information would give, however, if GPs cannot refer patients to consultants, any more than giving information on quality to patients who cannot use it.

3.9. ✂.

3.10. We further agree that publishing information on consultant fees on the PHIN website prior to the availability of information on consultant quality becoming available would entail dangers of a "race to the top" (we pointed this out in our Reply to the PFR :paragraph A3.31 of Appendix 3).

3.11. It is important to realise that what is currently happening is a senseless "race to the bottom" ✂.

Raw Data

3.12. The CC relays what BUPA have highlighted in relation to hospital and consultant performance information at paragraph 2.415 of the January PDR Report:

> *"Bupa also highlighted the need for performance data, both on consultants and on hospitals, to be available to PMIs in a format which would allow them to carry out a range of more technical analysis on behalf of their customers. This would take the form of access to the raw datasets underlying the quality data produced on consultants (and hospitals)."*

3.13. In the context of Remedy 7 they are relayed by the CC at paragraph 2.438 as having made a similar statement:

> *"Bupa highlighted that PMIs needed access to the raw data underlying any quality measures in order to carry out their own analysis, rather than having access to the same outcome measures as patients."*

3.14. We see from 2.466 (f) that the CC plans to allow PMIs (and others) to obtain the raw data. If so, the CC needs to explain the purpose of this. ✂

3.15. The CC has noted the consultants' concerns here: *"we also note the concerns expressed by FIPO and numerous consultants that the interests of the PMIs are not necessarily aligned with those of patients. Therefore, we believe that it is appropriate for an independent organization to collect, analyse and publish this data and that this should be*

the primary data source to which patients should be referred". (Paragraph 2.481 January PDR Report).

3.16. ✂.[14]

3.17. ✂.

[14] ✂.

4. REMEDY 4 – CLINICIAN INCENTIVE SCHEMES

- We agree that action must be taken against incentives likely to result on referrals to hospitals
- We consider that the CC should recognise that consultants are driven by professional considerations in the best interest of their patients
- The £500 limit is disproportionate; difficult to monitor and can have unintended consequences especially for training and private hospitals.

4.1. We have expressed our view previously that we are in principle against incentives where they are linked to referrals, however we noted that certain equity arrangements can be beneficial to innovation. We are generally in agreement with the proposed Remedy 4 and note that several queries raised by us at paragraph 1.6 of our Reply to the PFR have been addressed, as discussed briefly below.

- In our Reply to the PFR at paragraph 3.11 we referred to **express contractual obligations to refer** being one of the more harmful types and are pleased the CC has recognised this and that such requirements to refer, whether express or implied are now prohibited.

- In our 3.14 we mentioned the **merits of equipment investment**, which has been allowed under Remedy 4, subject to the proviso that it is declared on the hospital website and its use not linked to a contingent equity share.

- We are pleased the CC has **focussed the remedy on hospital/clinician ownership, only where a hospital group is involved** (paragraph 2.405 the January PDR Report), and the remedy's criteria does not apply to clinician only investments.

4.2. We raise some concerns in relation to the proposed Remedy 4 below.

Consultants and referrals

4.3. First, in our Reply to the PFR paragraph 3.15-3.16, we raised the question as to the evidence that consultants are likely to make referrals because of a financial incentive. Spire expressed similar opinions, which were published in the PFR (paragraph 2.308). Spire, like FIPO, considered that CC had "***overstated the scope and potential impact of incentive arrangements***". It agreed with the CC (and FIPO) that "*ethical and regulatory constraints which apply to consultants could be expected to offset to a substantial extent any economic incentive for a consultant to offer advice that was not in the patient's best interest*". We consider that it would be important that the CC recognises that consultants are professionals driven by a need to treat patients and that the remedy on incentives is driven by a need to ensure that the most wide-ranging incentives are stamped out, in the interest of the medical profession remaining a trusted profession, and being seen to be so. At present, reading the January PDR Report we are struck by the easy assumptions underlining this remedy that consultants will be driven by hospital incentives in the provision of medical care.

Fair Market value

4.4. Second, we refer the CC to paragraph 2.391 (a) of the January PDR Report which refers to **Fair Market Value** in relation to equity stakes. In our Reply to the PFR (paragraph 3.14) we asked for guidance on this and are surprised to see that there is none yet save for a vague reference to a formula in footnote 169.

De-minimis of £500

4.5. ✂.

4.6. We are unclear where this figure has come from? We note that in footnote 143, Bupa had apparently said "*that a very low de minimis threshold exemption – an indicative level may be £500 per doctor a year – could be acceptable to cover, for example, social events, promotional stationary, or facilities for training events. Such payments may not sufficiently affect consultant behaviour (in particular, referral patterns) to warrant prohibition*".

4.7. The CC states (at paragraph 2.377:

We thought that if the maximum value of the service provided was set at a very low level and declared on the hospital's website then, even if disagreements did arise over the value of a service being provided, the risk to the effectiveness of the remedy would be low since the likelihood that services so inexpensive would influence doctor behaviour would also be low. We thought that a limit low enough to permit private hospitals to offer doctors free tea and coffee, newspapers and magazines, stationery, general marketing and in-house training, for example, would be appropriate. We provisionally decided that an upper limit of £500 a year (equivalent to less than 1 per cent of a consultant's NHS starting salary) on the cumulative value of such services that an individual hospital could provide to a clinician would be reasonable. In order to achieve transparency we decided that the services of this nature which a private hospital was providing to clinicians and which it claimed fell below our limit should be disclosed on the hospital's website.

4.8. ✂.

4.9. It may be a timely reminder for the CC to consider the price of capsules for coffee makers as the proxy for the cost of coffee (not taking into account the cost of the machine and other costs). Nespresso Assortment of 200 capsules costs £62.20 (at today's prices). A consultant who drinks two coffees per day would cost the hospital more than £100 in coffees only. There is very little wriggle room for tea, stationary, newspapers and magazines. Crucially, there is very little that can be done for in-house training within this limit. In-house training is arguably the life and blood of a hospital; it is a requirement. Whilst much training is carried out in the NHS there is a core of essential training and academic activity within the private sector (for example for fully independent consultants). To curtail it to this extent is unnecessary and will almost inevitably lead to counterproductive medical results. None of this would lead to, or is contingent, on the consultant referring more patients to the hospital. The remedy is entirely disproportionate to its legitimate aim.

4.10. Overall, it appears to us that enforcement[15] of such a limit will be difficult (who will count the numbers of coffees drunk?), possibly lead to more bureaucracy and costs and would still be liable to misinterpretation or abuse. FIPO is fully supportive of a remedy which

[15] Effectiveness of a remedy is also mentioned by the CC in terms of enforcement – see paragraph 8.4 of Part II.

excludes consultants from having secretarial or consulting rooms or other major practice support (perhaps with the proviso that newly appointed consultants may get discounted room rates for the first 12 months of their practice, as we have mentioned (paragraph 3.22 of our Reply to the PFR) - this would be a good way to allow new consultants' entry but we are not sure why the CC has not considered our suggestion). The remedy imposed will have to be easily monitored to be fit for purpose.

PART II

5. INTRODUCTION TO PART II

5.1. In this Part II we put forward our arguments in relation to how the CC has conducted the investigation, and highlight where we think that it has not acted within its powers as a decision maker should. The CC will appreciate that, although consultants lack the financial resources of the major PMIs, patients' choice; medical care based on medical training; and professional standing are fundamental issues of survival for the consultants currently in private practice.

5.2. Having said this, we do realise that a number of changes are afoot, with the changeover from the OFT/CC to the new unified authority, the CMA, created under the Enterprise and Regulatory Reform Act 2013("**ERRA13**"). ✂[16]. We have heard nothing since, despite asking for information. The FSA was possibly too big an organisation to follow up on the OFT's request to consider the issues, but the new Financial Conduct Authority (FCA) with its focus on protecting consumers may be better placed to consider the issues.

5.3. Further, whilst currently under the EA02 the OFT can conduct market studies into features that are common to a number of markets but cannot make a reference to the CC to investigate those features without also referring the whole of each market concerned, this is set to change with the ERRA13. ✂.[17] ✂. The statements made by the CC throughout this investigation and replicated below (in the diagram at point 6.1 below) rather suggest that this possibility could be used to analyse the issues that the CC identified but did not follow.

5.4. ✂, deciding instead to focus all resources of this investigation on the CC's work in relation to divestiture of hospital groups. Still, this should be made clear to the consultants.

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[16] ✂
[17] ✂

6. INCONSISTENCY IN THE CC REASONING

6.1. Now we turn to the CC's reasoning. ✂.

DIAGRAM

✂

6.2. This reasoning does not make sense to us. The CC has identified an AEC on the basis of distortion of ***competition between consultants by preventing patients from exercising effective choice in selecting the consultants by whom to be diagnosed and treated*** resulting from lack of information forgetting about the conduct of insurers, which also restricts choice, and was noted by the CC in the AIS (e.g. paragraph 118: "*We understand that Bupa is now only recognizing new consultants if they enter into a contract with Bupa directly which stipulates how much they will charge to its patients… We are concerned that these practices can be expected to lead to a reduced choice of consultants available to patients insured by these insurers*").

6.3. For the avoidance of doubt, we understand that, in the course of a long investigation such as this, the thinking evolves and may change but if there has been evolution on the issues that concern consultants most, we have not followed it. We have rather experienced this investigation as a trajectory from early identification of the issues to abrupt failure to address these.

6.4. ✂.

6.5. ✂.

7. THE "FOUR CORNERS OF THE LAW" – INCORRECT INTERPRETATION OF EA 2002

Market Definition and Market Analysis

7.1. We pointed out already that the CC cannot as a matter of law proceed irrespective of the markets it identifies. ✂.

Future detriment under The EA

7.2. This has not been adequately considered by the CC. Paragraph 1.9 of our Reply to the PFR mentioned "future customers" in the context of detriment and we notice that the CC has picked up this point and noted at Paragraph 1.13/4 of the January PDR Report: *"A detrimental effect on customers includes such an effect on future customers and is defined as one taking the form of:* (a) *higher prices, lower quality, or less choice of goods or services in any market in the UK (whether or not the market to which the feature or features concerned relate)".* ✂.

Effectiveness of Remedies

7.3. Pursuant to Section 136 2 (a) of the EA 2002 the Commission must provide a report which contains decisions on questions it is required to answer under Section 134 (in relation to the existence or not of an AEC). In the January PDR Report at paragraph 1.20: "*Where the CC finds that there is an AEC, it has a duty, under the Enterprise Act, to decide whether action should be taken by the CC, or recommended for others, to remedy, mitigate or prevent the AEC and any detrimental effects on customers resulting from it*".

7.4. At paragraph 1.15 of the January PDR Report, the CC explains:

"*In deciding what remedy or remedies would be appropriate, the CC will first look for a remedy that would be* ***effective in achieving its aims****. The CC has made several general observations in its guidance about factors relevant to its consideration of effectiveness.*[18] *First, a remedy should be capable of effective implementation, monitoring and enforcement. The effectiveness of any remedy may be reduced if elaborate monitoring and compliance programmes are required. Second, the CC will take into account the time period over which a remedy is likely to have effect, including how quickly the remedy will take effect and the expected duration of the AEC that the remedy is designed to address. A third consideration is* ***the way in which remedies will interact with each other*** *and with any other existing or expected regulation of the relevant market".*

7.5. At paragraph 1.16:

In considering the reasonableness of different remedy options, the CC will have regard to their ***proportionality****. In making an assessment of proportionality, the CC is guided by the following principles. A proportionate remedy is one that (a) is effective in achieving its*

[18] *CC3, Guidelines for market investigations: Their role, procedures, assessment and remedies*, April 2013, paragraph 333

legitimate aim; (b) is no more onerous than needed to achieve its aim; (c) is the least onerous if there is a choice between several effective measures; and (d) does not produce disadvantages which are disproportionate to the aim.

7.6. ✂. The information on quality made available by PHIN will only be useful if patients and GPs can exercise choice in choosing consultants. Remedy 4 imposes an unnecessarily low limit on the provision of essential training services, is disproportionate and difficult to monitor and enforce.

8. CONSULTATION PROCESS

8.1. When conducting a consultation the CC does not enjoy ultimate unlimited discretion, and must adhere to certain fundamental factors. ✂.

8.2. The purpose of a consultation is surely to engage with the parties on their concerns. Reasons are put forward, considered and responded to. When the consultants within FIPO spend time and resources commissioning a survey of consultants to show the trends in private healthcare, they are entitled to expect that the CC will consider it and engage on the findings. When the CC identifies a market, they expect that the market will be analysed and that they will see the findings in the various interim reports.

8.3. Consultants are entitled to more consideration of the core issues of concern to them than what the CC has given them (We take note that the views expressed by the individual consultants so far have merited one appendix summarising them). ✂[19] ✂.

8.4. We would argue that the CC has focussed almost obsessively on hospital divestitures. We are aware of the pressures on the CC and do not expect that the chief of the enquiry would be poring over FIPO's response, ✂. This is poor administrative practice.

8.5. In addition, although the CC claims: *"Our final decision on **any AECs, and appropriate remedies**, will take into account all evidence received and submissions made including the responses to our provisional findings and provisional decision on remedies"*, we consider

[19] ✂.

that the duty to consider all the evidence received will not be discharged by publication of an Appendix in the final report. ✂.

9. FAILURE TO CONSIDER RELEVANT FACTORS

9.1. The evidence of patient detriment has been side-lined. As the CC will see from paragraph 1.5 of our Reply to the PFR, we consider that this issue lies at the heart of the investigation. A recent example of a patient whom we are trying to advise illustrates the issues. ✂.

9.2. ✂.

9.3. No AEC has been identified in relation to issues such as this. We refer in this regard to paragraph 4 of the PDR where the CC explains: *"We have not, at this stage, made a final decision regarding the existence and form of any AEC and/or resulting customer detriment."* We are not asking the CC to have made a "final decision" but now we are not even sure that the CC has considered the issue of patients' detriment properly.

9.4. In JR terms, ✂

9.5. ✂

9.6. ✂.

10. IRRATIONALITY

10.1. The CC will be familiar with the decision in ✂

10.2. ✂

10.3. ✂, we consider that omission of proper and due consideration of patient detriment, an issue that lies at the centre of this investigation, and failure to consider the difficulties that patients and GPs have in selecting consultants of choice may not be within the remit of what a reasonable decision maker would do.

APPENDICES

1. ✂
2. ✂
3. PRESS ARTICLE
4. ✂
5. COMPETITION COMMISSION GFK SURVEY (SLIDE 32)

APPENDIX 1

APPENDIX 2

APPENDIX 3

PRESS ARTICLE ON HEALTHCARE DATA

The Economist

February 1, 2014

U.S. Edition

Need to know;

Measuring health care

SECTION: INTERNATIONAL

To improve health care, governments need to use the right data

DECIDING where to seek treatment might seem simple for a German diagnosed with prostate cancer. The five-year survival rate hardly varies from one clinic to the next: all bunch around the national average of 94%. Health-care providers in Germany, and elsewhere, have usually been judged only by broad outcomes such as mortality.

But to patients, good health means more than life or death. Thanks to a study in 2011 by Germany's biggest insurer, a sufferer now knows that the national average rate of severe erectile dysfunction a year after removal of a cancerous prostate gland is 76%--but at the best clinic, just 17%. For incontinence, the average is 43%; the best, 9%. But such information is the exception in Germany and elsewhere, not the rule.

What matters to patients should also matter to policymakers. Side-effects such as erectile dysfunction and incontinence are not only unpleasant, but expensive to treat. And measuring outcomes is the first step to choosing the best treatments and providers at the lowest prices. But few places do this well, says Michael Porter of Harvard Business School.

Doctors and administrators have long argued that tracking patients after treatment would be too difficult and costly, and unfair to providers lumbered with particularly unhealthy patients. But better sharing of medical records and a switch to holding them electronically mean that such arguments are

now moot. Risk-adjustment tools cut the chances that providers are judged on the quality of their patients, not their care.

In theory, national health-care systems should find measuring outcomes easier. Britain's National Health Service (NHS) compiles masses of data. But it stores most data by region or clinic, and rarely tracks individual patients as they progress through treatment. Sweden's quality registries do better. They analyse long-term outcomes for patients with similar conditions, or who have undergone the same treatment. Some go back to the 1970s and one of the oldest keeps records of hip replacements, letting medics compare the long-term performance of procedures and implants. Sweden now has the world's lowest failure rate for artificial hips.

Elsewhere, individual hospitals are blazing a trail. Germany's Martini-Klinik uses records going back a decade to fine-tune its treatment for prostate problems. The Cleveland Clinic, a non-profit outfit specialising in cardiac surgery, publishes a wide range of outcome statistics; it now has America's lowest mortality rate for cardiac patients. And though American politicians flinch at the phrase "cost-effectiveness", some of the country's private health firms have become statistical whizzes. Kaiser Permanente, which operates in nine states and Washington, DC, pools the medical records for all its centres and, according to McKinsey, a consultancy, has improved care and saved $1 billion as a result.

Such approaches are easiest in fields such as prostate care and cardiac surgery, where measures for quality-of-life are clear. But some clinics have started to track less obvious variables too, such as how soon after surgery patients get back to work. This is new ground for doctors, who have long focused on clinical outcomes such as infection and re-admission rates. But by thinking about what matters to patients, providers can improve care and lower costs at the same time.

APPENDIX 4

APPENDIX 5

COMPETITION COMMISSION GFK SURVEY (Slide 32)

Most important reasons for choosing private consultant

Clinical expertise and reputation of the consultant were the most common reasons for choosing a private consultant, though waiting time and recommendation were also important.

C6. Once you had decided to go private, what were the most important reasons for choosing which private consultant to see?

Base: All private hospital patients who saw a consultant (1258), Who paid via PMI (1134), Who self-paid (124), All PPU patients who saw a consultant (83)