

# **Private Healthcare Market Study**

Report on the market study and final decision to make a market investigation reference.

April 2012

OFT1412

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Any enquiries regarding this publication should be sent to us at: Marketing, Office of Fair Trading, Fleetbank House, 2-6 Salisbury Square, London EC4Y 8JX, or email: [marketing@oft.gsi.gov.uk](mailto:marketing@oft.gsi.gov.uk).

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# 1 EXECUTIVE SUMMARY

- 1.1 Following a consultation, the OFT has decided to refer the market for privately funded healthcare services in the UK (PH) to the Competition Commission (CC) for a market investigation. This report sets out the OFT's reasons for referring the market.
- 1.2 The market investigation reference follows an in-depth market study of PH by the OFT launched in March 2011, and a consultation document on a proposal to refer the market which was published in December 2011.
- 1.3 The market for PH encompasses a range of medical treatments which are privately funded, either directly by patients or through their private medical insurance (PMI) policies, and provided to patients by consultants, medical and clinical professionals in private hospitals, clinics or units (PH facilities).
- 1.4 The total value of the market for acute PH in the UK was approximately £5 billion in 2010. Private hospital and clinics account for the largest part of this figure, generating an estimated £2.89 billion in revenue during 2010.<sup>1</sup> Approximately 78 per cent of acute PH purchases are made through patients' PMI policies.<sup>2</sup> On average 15.8 per cent of people are covered by such a policy in the UK (PMI funded patients).<sup>3</sup>
- 1.5 The market for PH is likely to be an area of growing importance to the UK economy given, in particular, that demand for healthcare services is forecast to grow in line with an expanding and ageing UK population.<sup>4</sup> It may also be increasingly important to the delivery of NHS services

<sup>1</sup> Laing & Buisson, *Laing's Healthcare Market Review 2011-2012*, Table 2.1 page 38. Note the total market figure does not include revenue from the purchase of acute care or mental health by the NHS from independent facilities, revenue from mental health facilities, rehabilitation, termination of pregnancy, or screening.

<sup>2</sup> Laing & Buisson, *Laing's Healthcare Market Review 2011-2012*, Figure 2.4 page 43. Note the percentage excludes NHS purchases of acute care from independent facilities.

<sup>3</sup> Keynote, *Private Healthcare Market Report*, 2011 Table 6.1 page 51.

<sup>4</sup> Keynote, *Private Healthcare Market Report*, 2011.

following the passage of the Health and Social Care Act enabling providers of PH to play a larger role in delivering NHS treatment.

- 1.6 Through market studies, the OFT is able to undertake a holistic analysis of markets, drawing on its experience and understanding of competition and consumer problems across a wide range of markets. In addition to this, the OFT has developed specific expertise on competition and consumer problems across a range of health markets, including pharmaceuticals and NHS equipment. It has previously considered the PH market in 1999 and in recent merger decisions in 2010.
- 1.7 While the focus of this market study has been on privately funded healthcare for private patients, the OFT has also been aware of the developing linkages between PH and NHS services. It has focused, therefore, where appropriate and relevant, on setting out the OFT's analysis and conclusions in this report with a view to assisting those bodies with ongoing and new roles in regulating or reviewing healthcare services, such as Monitor as the sector regulator for health.
- 1.8 The PH market clearly provides a valuable service which benefits patients. However, having considered carefully the consultation responses, the OFT considers that there are a number of features of this market that, individually or in combination, prevent, restrict or distort competition. The consequence is that therefore the threshold test for making a market investigation reference (MIR) to the CC is met.
- 1.9 The OFT considers that the features of the PH market outlined below, in particular, the combination of information asymmetries, high concentration and barriers to entry in the PH market appears to result in reduced choice for patients. They may also restrict competition between PH providers and between consultants by impairing the ability of patients, GPs and PMI providers to choose between competing service providers, including new entrants, on the basis of superior quality and better value for money. This might be expected to result in higher prices and lower quality of services for patients and innovation in the PH market. The consumer harm that the features generate affects all PH patients to some extent.
- 1.10 **Information asymmetries:** As analysed in chapter 5, the OFT considers that there is a shortage of accessible, standardised and comparable information provided to patients and their advisors in relation to the

quality of PH facilities and of consultants. There also appear to be difficulties for PMI funded patients in assessing the risk of shortfall from particular consultants, whereby a consultant's fees exceed the benefit maxima that the patient's PMI provider will reimburse resulting in the potential for an additional payment by the patient. In addition, for self-pay patients, there are difficulties in easily comparing the prices charged by different PH facilities.

- 1.11 In general, the OFT considers that this shortage of accessible, standardised and comparable information weakens the ability of patients and GPs to drive efficiencies and stimulate enhanced competition between rival PH facilities and between consultants, and may give rise to a dampening of competition in the market overall. The lack of access to information on quality and price for consultants appears to produce a situation where both the patient and PMI provider cannot differentiate between consultant performance and fees in order to judge whether they represent value for money. This may be preventing the development of more flexible, less distortive methods for PMI providers to control consultant costs, whereby patients can choose between consultants on the basis of their respective fees and quality and pay a top-up fee to the consultant, above the maximum provided by their insurance cover, if a patient judges it to be worthwhile.
- 1.12 Finally, the OFT notes that information asymmetries are a factor across a number of other features examined in this report, including the limits on the ability of PMI providers to exercise buyer power which is examined in chapter 6. The lack of access to comparable quality information on PH facilities may also facilitate a competitive dynamic whereby competition between PH providers is based less on the quality of services provided to patients and, since a consultant often effectively seems to choose at which PH facility the patient is treated, more on attracting consultants to their PH facilities through the use of a variety of contractual and non-contractual incentives. This may increase the cost of PH without necessarily driving improvements in the quality of services provided to patients. The development of consultant incentives is examined in chapter 8.
- 1.13 **Concentration:** PH provision appears to be concentrated at the national level. At the local level there appear to be examples of extreme concentration, such as areas where there is no alternative fascia PH

facility within a 30-minute drive time of a particular PH facility (solus PH facilities). In addition, the OFT notes widespread concerns raised in submissions in response to the consultation document about the existence of 'must-have' facilities. While the OFT has not taken a definitive view on whether particular facilities are 'must have', it considers that there are likely to be a number of local markets with a high degree of concentration, such as those areas with only two PH facilities within a 30-minute drive time.

- 1.14 For the reasons set out in chapter 6, including the desire of patients to be treated locally, there are reasonable grounds to suspect that these levels of concentration restrict competition in the provision of PH.
- 1.15 The purchasing of PH provider services is also concentrated at the national level. The size of the largest PMI providers appears to provide them with some buyer power in that PH providers are, to an extent, dependent on access to, and inclusion on, the networks of these larger PMI providers for the financial viability of their PH facilities. The emergence of 'low cost' PMI networks, open referrals and the recent delisting of hospitals by one of the largest PM providers support the existence of some buyer power at least among the largest PMI providers.
- 1.16 However, there may be limits on the PMI providers' ability to exercise such buyer power. Firstly, the degree of any such buyer power is likely to vary by size of the PMI provider in terms of its share of subscription income, and it is likely that not all PMI providers are large enough, on this basis, to exercise buyer power. Secondly, any buyer power may be constrained by the need for PMI providers to purchase PH in most local markets, including areas with solus PH facilities as described above, in order that their policyholders can be treated locally. Thirdly, PMI providers are likely to face at least some reputational costs if they carry out a threat to delist or exclude PH facilities from PMI networks. Further, beyond the exclusion of PH facilities from their networks, PMI providers have limited ability to direct patients to different PH facilities since in most cases GPs rather than PMI providers recommend the consultants, and consultants often determine a patient's choice of PH facility.
- 1.17 The OFT notes that the development of partnership arrangements between the PPU's of NHS/Foundation Trusts and PH providers has the potential to either exacerbate or alleviate any concentration concerns in

local PH markets. Local market concentration may increase if a PH provider that is already present in the local market partners with the PPU. This is because the partnering arrangement may lessen the competitive constraint on the relevant PH provider offered prior to the partnering arrangement and reduce choice for PH patients and PMI providers. On the other hand, a partnership arrangement between a PPU and a new PH provider in the local market has the potential to provide a platform for entry and thereby to increase competition. As a result of this market study, the OFT has made a recommendation to the NHS/ Foundation Trusts in relation PPU partnering arrangements.

- 1.18 **Concentration of anaesthetists:** As examined in chapter 7, 44 per cent of anaesthetists are part of a group (AG). Prior to, and during the course of, the market study, the OFT received a number of complaints from patients regarding their inability to find an anaesthetist who will charge within PMI provider fee schedules. These complaints have been supported by submissions and evidence from PMI providers as part of the market study that high concentration of AGs in some local markets may raise prices. In the light of these complaints, the OFT suspects that the prevalence of AGs is also a feature of the market which may reduce price competition in local markets (particularly in view of switching costs such as the costs associated with postponing treatment or travelling to an alternative facility).
- 1.19 **Barriers to entry:** For the reasons analysed in Chapter 8, the OFT considers that a number of features of the PH market combine to create significant barriers to entry. These are:
- Certain conditions imposed by larger PH providers as part of the recognition of their facilities on PMI networks which may restrict the ability of PMI providers to recognise new entrants attempting to offer competing PH services on their networks. For example, some PH providers impose conditions on PMI providers that they be consulted on the recognition of a new entrant on a PMI providers' network, or that impose price rises on a PMI provider should a new entrant be recognised.
  - A combination of the need for wide PMI network recognition and the 'consultant drag' effect. As many consultants prefer to treat most of their private patients at one main PH facility, and patients are insured

by different PMI providers, new entrants need to be recognised on all of the main PMI networks in order to attract a sufficient number of consultants to practice at their facility.

- Incentives paid directly or indirectly by PH facilities to consultants to encourage them to treat all, or a higher number, of their patients at their facility. These incentives may further discourage consultants from treating patients at the facilities of new entrants, attempting to offer competing PH services.
- In addition, in this context, the OFT notes the possibly emerging trend of the provision of financial incentives to GPs by PH providers with local market power, in order to encourage those GPs to refer patients to the PH provider's facilities. This trend may also have the potential to develop as a barrier to entry.

1.20 The OFT notes that many of these features are intrinsically linked to the other aspects of this market examined in chapters 5 and 6. For example, the shortage of comparable quality information on PH facilities, examined in chapter 5, may make it harder for new PH provider entrants to establish a reputation for quality in the market by which to attract consultants and patients away from incumbent PH providers.<sup>5</sup>

1.21 This combination of concerns around information asymmetries, aspects of local concentration and wider barriers to entry, either individually or in combination, has the potential to prevent, restrict or distort competition in the PH market. The OFT considers that these significant underlying features of the PH market are more appropriately investigated further by way of a MIR and that the CC has recourse to the range of remedies which may prove appropriate if the CC concludes that any features of the market have an adverse effect on competition. Such remedies could include, for example, compelling the provision of certain information, the imposition of supply or pricing obligations on certain PH facilities, or

<sup>5</sup> Although a number of submissions considered that it was the relationship between the PMI and the larger PH providers and addressing the information asymmetries would not resolve the issues regarding concentration and barriers to entry.

potential bans on the imposition by PH providers of certain types of contractual provisions.

1.22 The OFT considers that the statutory test in section 131 of the Enterprise Act 2002 for making a reference is met and, taking into account the relevant criteria set out in the OFT's guidance document on MIRs, has concluded that the evidence points in favour of exercising the OFT's discretion to make a reference to the CC for the supply and acquisition of PH. These reasons are set out in chapter 10.

### **Conclusion on the reference**

1.23 Having regard to all the evidence received during the market study and the consultation, the OFT finds that there are reasonable grounds to suspect that there are features of the PH market which, both individually and in combination, prevent, restrict or distort competition in the UK. The statutory threshold test for a reference to the CC is therefore met.

1.24 Furthermore, the OFT considers that it is appropriate to make a reference to the CC, considering in particular that:

- The PH industry is of growing importance to both the nation's population and economy.
- There is a reasonable prospect of finding appropriate remedies if the CC concludes that there are competition concerns.
- In all the circumstances, an MIR is the most appropriate tool for investigating and potentially remedying the market features identified in this first phase enquiry. Further, the CC has the investigatory and remedial scope and powers needed to analyse and address (if appropriate) these features.

1.25 A number of the larger PH providers made submissions in response to the consultation document opposing a reference. In this context, the OFT notes that the threshold test in section 131 requires the OFT to have reasonable grounds to suspect that there are features of a market that may restrict, distort or prevent competition. While the OFT accepts that it has a discretion on whether or not to make a reference in circumstances where the threshold test is satisfied, this is exercised within the context of the first phase enquiry. The OFT is satisfied that it

is appropriate, following this first phase enquiry, for there to be a detailed investigation of this market, and the appropriate body to carry out that investigation is the CC. The making of this MIR does not imply any pre-judgment as to what the CC's findings or conclusions will be.<sup>6</sup>

1.26 The OFT has therefore decided to make a reference to the CC under section 131 of the Enterprise Act 2002 for an investigation into the PH market in the UK. This confirms the OFT's proposed decision.

1.27 The terms of reference are set out in Annexe A.

### **Other market study findings**

1.28 This report makes two recommendations to address particular issues that arose in the course of the market study.

1.29 First, responding to concerns expressed by consumers as to the level of extra payments sought from some consultants that are not covered under their PMI policies (shortfall payments), the OFT has engaged with the Financial Services Authority (FSA) on this issue. As a result, the Association of British Insurers (ABI) has confirmed to the FSA, on behalf of its members, that PMI providers will either cover the total cost so that no shortfall arises, or will make clear the possibility of a shortfall payment as a result of the limits which apply to the amount payable under their policies. The aim will be to ensure that PMI providers make the risk of shortfall payments clear to their customers both at the point of sale and at the time a patient makes a claim under a PMI policy. The OFT welcomes this development.

1.30 Second, noting the development of partnership arrangements between PPU's of NHS/Foundation Trusts and PH providers, as discussed above, the OFT has made a recommendation to the NHS/Foundation Trusts when seeking to agree partnership arrangements to consider whether

<sup>6</sup> The OFT notes previous remarks by Sir Christopher Bellamy, the then President of the Competition Appeals Tribunal, in the appeal of the Association of Convenience Stores (ACS) v OFT in 2005 in relation to the nature of the test in section 131 Enterprise Act 2002. He stated:

'Is it not the intention that the first stage, the OFT stage, is not intended to be a deep and prolonged investigation in which every avenue is exhaustively looked at? That is for the CC stage.' ACS v OFT: Case Management Conference (2005).

PPUs may be at a potential competitive advantage in PH markets due to any implicit, non-market benefits they could receive from their connections to NHS/ Foundation Trusts. Chapter 9 therefore considers how the principles of competitive neutrality might apply to publicly funded organisations competing in the PH market.

## 2 INTRODUCTION

- 2.1 The OFT aims to make markets work well for consumers. It achieves this by promoting and protecting consumer interests throughout the UK, while ensuring that businesses are fair and competitive.
- 2.2 The OFT is well placed, with its unique market study tool, to pursue valuable, holistic analyses of markets – both from a competition and consumer angle. Market studies are a non-intrusive and efficient instrument for diagnosis, cure or both. They can ensure that issues are not left unexamined. They can also be a means of applying informed technical skills to bespoke analyses of issues, such as whether barriers to competition are on the supply side or the demand side, whether they may be remediable and whether any potential remedies might have unintended consequences.
- 2.3 The OFT has embarked on this market study with considerable experience of considering issues across sectors related to the PH sector, having considered several mergers across privately funded healthcare services and PMI sectors and most recently having reviewed the merger of two PH providers in October 2010.<sup>7</sup> However, the last formal market review of the provision of PH was more than a decade ago, in 1999.<sup>8</sup> The OFT also has a decade of experience of using and developing its market study tool.
- 2.4 This market study comes at a time of change in the wider landscape of healthcare provision in the UK, although no significant changes are anticipated to the PH market in the UK in the short-term. The OFT has engaged with a wide range of stakeholders throughout this market study and has focused, therefore, on setting out its conclusions in this report

<sup>7</sup> Since 2008 three mergers have been reviewed by the OFT in this sector, these are: (i) Completed acquisition by General Healthcare Group of control of four Abbey hospitals and de facto control over Transform Holdings Limited previously part of the Covenant Healthcare Group, October 2010, (ii) Completed acquisition by Spire Healthcare Limited of Classic Hospitals Group Limited, July 2008, and (iii) Completed acquisition by General Healthcare Group of assets of Nuffield Facilities, May 2008. The most recent being the Completed acquisition by General Healthcare Group of control of four Abbey hospitals and de facto control over Transform Holdings Limited previously part of the Covenant Healthcare Group, October 2010.

<sup>8</sup> See [www.offt.gov.uk/shared\\_offt/market-studies/40\\_99.pdf](http://www.offt.gov.uk/shared_offt/market-studies/40_99.pdf)

with a view to assisting regulatory bodies with ongoing and new roles in regulating or reviewing healthcare markets.

- 2.5 The OFT launched the PH market study in March 2011 following its own preliminary research, prompted by submissions made by a number of participants across the sector, which together called into question whether the market for PH is working well for consumers. This research pointed to a number of changes in the market for PH over the last decade, in particular consolidation amongst PH providers since the last OFT review in 1999, a move by PMI providers away from vertical integration and an evolving, and potentially more complex, interaction between the PH market and the NHS.
- 2.6 The PH market may also be increasingly important to the delivery of NHS services following the passage of the Health and Social Care Act and ongoing policies such as the 'Any Willing Provider' initiative, which are aimed at enabling NHS patients to obtain medical treatment from PH providers. The NHS is the second largest purchaser of PH and the proportion of NHS patients treated in PH facilities has more than doubled in the last four years.<sup>9</sup>
- 2.7 The OFT published the consultation document, including a proposal to refer the market to the CC on 8 December 2011.<sup>10</sup> This report provisionally found there to be certain features of the PH market which prevented, restricted or distorted competition, including information asymmetries, concentration in the PH provider market and barriers to entry.
- 2.8 The OFT invited views and evidence in response to the consultation document as well as the proposal to make a reference. This consultation period ended on 30 January 2012. The OFT has considered all the responses received carefully and met with some stakeholders to obtain further information or to clarify the material they had provided. In total, the OFT received responses from 50 people and organisations, consisting of:

<sup>9</sup> Laing & Buisson, *Laing's Healthcare Market Review 2010-2011*, page 44.

<sup>10</sup> See [www.of.gov.uk/shared\\_of/market-studies/OFT1396\\_Private\\_healthcare.pdf](http://www.of.gov.uk/shared_of/market-studies/OFT1396_Private_healthcare.pdf)

- five larger PH providers
- four PMI providers
- four medical organisations
- nine smaller PH providers
- 17 medical professionals
- 11 others including patients, trade bodies and others

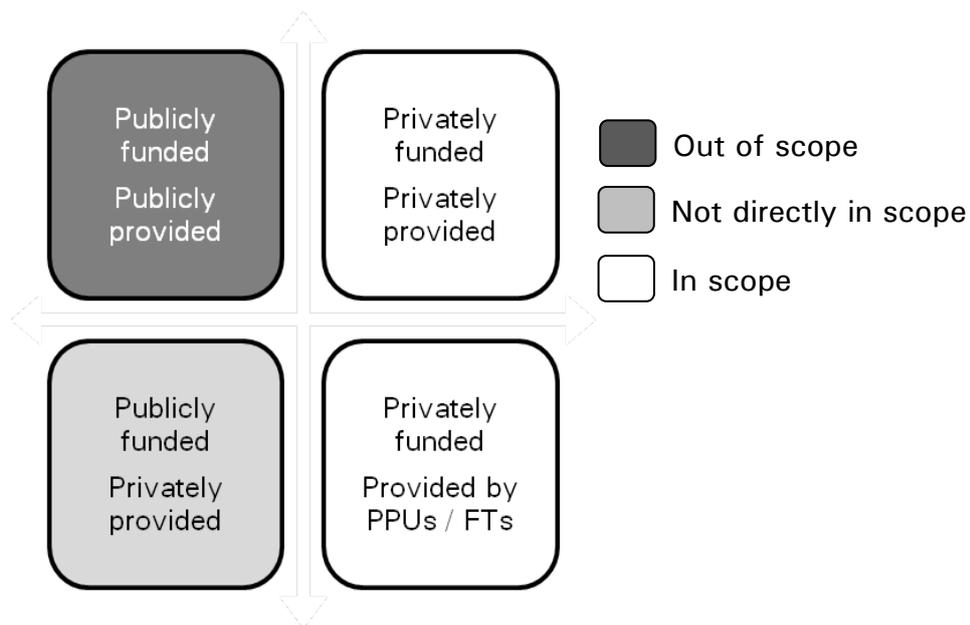
2.9 Of these responses, four did not support the proposed reference, 22 were supportive of a reference and a further 24 provided comments on issues discussed in the consultation document, but did not express an explicit view on whether the market should be referred to the CC.

### Scope of the Market Study

2.10 The focus of the market study is on the provision of PH, which includes the provision of PH by privately funded public providers (for example, by PPU of NHS/Foundation Trusts as well as private providers).

2.11 This is depicted in Figure 2.1 below, which also shows that publicly funded healthcare provided by the NHS is not within the scope of this study.

**Figure 2.1 Focus on privately funded healthcare**



2.12 The NHS's role as a purchaser of PH is also not directly within the scope of this market study due to various features which distinguish publicly funded healthcare from the PH market. In particular, pricing is set at the level of the NHS tariff<sup>11</sup> and the patient pathway and specification are set by the commissioning Primary Care Trust.<sup>12 13</sup> By contrast, PH patients generally receive a number of additional perceived benefits such as greater choice of consultant, the date of an outpatient appointment, and more immediate access to treatment. Pricing for PH, however, is negotiated separately with each purchaser, the large majority of whom are PMI providers acting on behalf of their customers (PMI funded patients) and this market study also examines this role.

2.13 The latest figures for PMI penetration show that approximately 15.8 per cent of the UK population are covered by a PMI policy.<sup>14</sup> The market

<sup>11</sup> See <http://data.gov.uk/dataset/payment-by-results-2010-11-national-tariff-information>

<sup>12</sup> See [www.nhs.uk/NHSEngland/thenhs/about/Pages/authoritiesandtrusts.aspx#primary](http://www.nhs.uk/NHSEngland/thenhs/about/Pages/authoritiesandtrusts.aspx#primary)

<sup>13</sup> Although not part of this market study, the NHS' role as a purchaser of PH was part of the Co-operation and Competition Panel's review of the 'Any Willing Provider' initiative, which reported in July 2011.

<sup>14</sup> Keynote, *Private Healthcare Market Report*, 2011.

study focuses particularly on the PMI providers' relationships with PH providers, consultants and GPs.<sup>15</sup>

## Overview of the PH Sector

- 2.14 The market for PH encompasses a range of medical treatments which are privately funded and provided to patients via private hospitals/clinics and PPU's (referred to in this report as 'PH facilities'),<sup>16</sup> through the services of consultants and medical and clinical professionals who work within these facilities.<sup>17</sup>
- 2.15 The OFT's consideration of PH has primarily focused on the provision of the acute<sup>18</sup> <sup>19</sup> medical/surgical and diagnostic procedures provided in such PH facilities (including acute facilities with overnight beds and acute day surgery facilities/clinics) to privately funded patients (PH patients).
- 2.16 In 2010, the total value of the sector for acute PH in the UK was estimated at just over £4.92 billion. PH facilities account for the largest part of the overall PH market, generating an estimated £2.89 billion in revenue during 2010. Fees to surgeons, anaesthetists and physicians generated an estimated £1.59 billion in 2010.<sup>20</sup> The remaining £0.45

<sup>15</sup> Private Healthcare – A Scoping Paper, OFT 1295, December 2010.

<sup>16</sup> Private Healthcare – A Scoping Paper, OFT 1295, December 2010. The scope of the market study does not include healthcare provisions performed outside of hospitals, such as healthcare at home or high street facilities.

<sup>17</sup> Chapter 4 sets out a consideration of the product market and geographic market definitions in relation to PH services in the UK.

<sup>18</sup> For the purposes of this market study, acute care is defined as short-term treatment via a range of medical/surgical procedures commonly delivered by PH facilities within inpatient and outpatient settings. This excludes treatment for long-term conditions.

<sup>19</sup> Private healthcare – final statement of scope, OFT 1295f, March 2011.

<sup>20</sup> Laing & Buisson, *Laing's Healthcare Market Review 2011-2012*, Table 2.1, page 38. Note the £4.92bn total market figure does not include revenue from the purchase of acute care or mental health by the NHS from independent facilities, revenue from mental health facilities, rehabilitation, termination of pregnancy, or screening.

billion is revenue generated by private inpatient and outpatient treatment in NHS facilities, for example PPUs.

## Evidence and Process

- 2.17 During the course of this market study and the consultation, the OFT has received a large number of submissions from a range of interested parties active across the PH market, including: PH providers, PMI providers, consultants, other medical professionals, and professional bodies.<sup>21</sup>
- 2.18 The OFT has also commissioned and published four reports from independent consultants.
- The first report contains findings from a survey of 400 GPs (the OFT GP survey) and 400 consultants (the OFT consultant survey) via telephone and on-line interviews, to provide evidence and information on the relationship and interactions between GPs, consultants and patients.<sup>22</sup>
  - Both these surveys were accompanied by a second report that sought to examine – mainly via a review of publicly available source information – the extent, nature and profile of the GP and consultant workforce in order to provide additional context for this market study (the OFT population report).<sup>23</sup>

<sup>21</sup> Such as the British Medical Association, Federation of Independent Practitioner Organisation and the Association of Anaesthetists of Great Britain and Ireland, consumer organisations and individual consumers.

<sup>22</sup> GHK, *Programme of Research Exploring Issues of Private Healthcare Among General Practitioners and Medical Consultants – Final Survey Report*, August 2011, available at: [www.oft.gov.uk/shared\\_oft/market-studies/Final-Survey-Report-08-2011.pdf](http://www.oft.gov.uk/shared_oft/market-studies/Final-Survey-Report-08-2011.pdf)

<sup>23</sup> GHK, *Programme of Research Exploring Issues of Private Healthcare Among General Practitioners and Medical Consultants – Population Overview Report*, August 2011, available at: [www.oft.gov.uk/shared\\_oft/market-studies/Population-Overview-Report-1.pdf](http://www.oft.gov.uk/shared_oft/market-studies/Population-Overview-Report-1.pdf)

- The third report covers research which involved in-depth interviews with 40 patients who had recently received, or were currently seeking private treatment (the OFT patient interviews).<sup>24</sup>
- The final report, commissioned by the OFT and undertaken by the economic consultants Oxera, assesses the different techniques for defining markets for PH in the UK (the OFT market definition report).<sup>25</sup>

2.19 In the interests of efficacy and transparency, the OFT also held a number of focused, follow-up sessions on specific issues with relevant market participants and sought input at various stages of this market study, including on its provisional views, from an expert panel comprising representatives from the Department of Health (DH), Monitor, the Competition and Cooperation Panel (CCP), the Care Quality Commission (CQC) and leading academics in health economics.

2.20 In early September 2011, the OFT also held two roundtable discussions with 36 different organisations (including those active in the PH sector and public bodies<sup>26</sup>) to consider its emerging views regarding the provision of price and quality information by consultants and PH facilities, and to investigate further whether the OFT's concerns in this area could be addressed and, if so, within what time frame. A high level summary of these discussions can be found at Annexe B of the consultation document.

2.21 This report presents the outcomes of the OFT's market study and the consultation and its recommendations as to the next steps. In particular, it presents the evidence and reasoning behind the OFT's decision to refer the PH market to the CC.

<sup>24</sup> Opinion Leader, *The Patient Journey: Research to support the OFT's private healthcare market study*, August 2011, available at:

[www.of.gov.uk/shared\\_of/market-studies/The-Patient-Journey-Report.pdf](http://www.of.gov.uk/shared_of/market-studies/The-Patient-Journey-Report.pdf)

<sup>25</sup> Oxera, *Techniques for defining markets for private healthcare in the UK*, December 2011, available at [www.of.gov.uk/shared\\_of/market-studies/Oxera\\_Market\\_definition.pdf](http://www.of.gov.uk/shared_of/market-studies/Oxera_Market_definition.pdf)

<sup>26</sup> Public bodies present at the roundtable discussions included: DH, CQC, and the Council for Healthcare Regulatory Excellence (CHRE).

2.22 The report is structured as follows:

- Chapter 3 provides an overview of the PH market and the patient journey for patients accessing PH
- Chapter 4 considers market definition, examining how the market for PH has national and local dimensions with potentially some regional aspects
- Chapter 5 considers issues around information asymmetries, outlining the types and availability of information to support informed choice with regard to accessing PH
- Chapter 6 considers the levels of concentration of PH and PMI providers in the PH market and whether these give rise to market power
- Chapter 7 examines the levels of concentration of anaesthetists
- Chapter 8 examines the conditions of entry and expansion in the PH market and whether there are barriers to new entrants
- Chapter 9 details other market findings and recommendations
- Chapter 10 sets out the OFT's reasons for making a Market Investigation Reference to the CC.

2.23 The OFT has been supported by a range of stakeholders during the course of this market study and consultation and would like to thank each of them for their input and for sharing their valuable knowledge of this sector.

### **3 MARKET OVERVIEW AND THE PATIENT JOURNEY**

#### **Introduction**

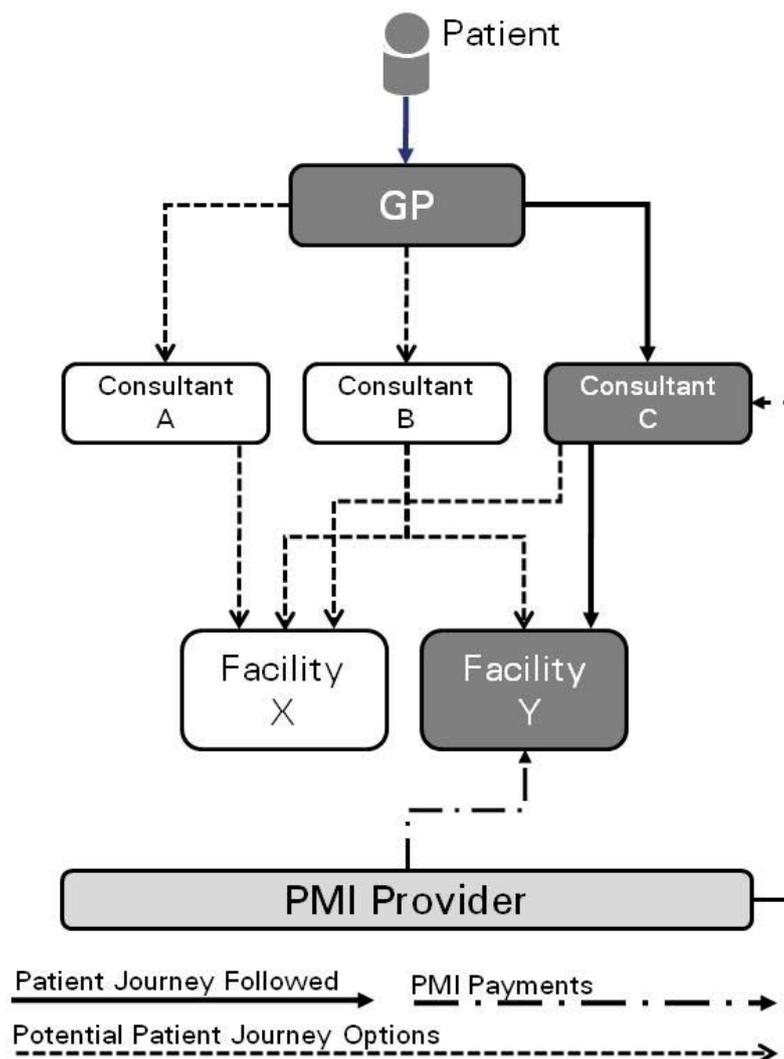
- 3.1 This section provides an overview of the PH market, exploring how the various market participants interact and the role of PMI in the context of PH. It also considers, where relevant, the role of privately funded public providers of PH, namely the NHS via the work of PPU's.
- 3.2 The PH market consists of five key participants: the PH patient, the General Practitioner (GP), the PH provider, the consultant, and, for most PH patients, their PMI provider. These five sets of participants are discussed in turn below.

#### **The Patient Journey**

- 3.3 The route a PH patient takes from requiring treatment through to being treated in a PH facility is often termed the 'patient journey'. Figure 3.1 below shows the typical patient journey, which is based on submissions from stakeholders, the OFT patient interviews, the OFT GP survey and the OFT consultant survey.
- 3.4 GPs act as the key interface in directing PH patients to consultants and PH facilities, and in the provision of information to PH patients about their options of PH provider and consultant. Consultants also occupy a central position within the patient journey as GPs refer patients to consultants (rather than to PH facilities) in the majority of cases. The roles of GPs and consultants are also examined below.
- 3.5 The patient journey presented in this chapter represents the typical route via which most PH patients will access PH. However, the OFT notes, as seen in the OFT patient interviews, that alternative routes are also possible where a patient may place greater or lesser reliance on the different market participants identified.<sup>27</sup>

<sup>27</sup> For more details on these alternative routes please see OFT patient interviews, pages 18-21.

**Figure 3.1 Typical Patient Journey for a PMI funded patient**



## PH Patients

- 3.6 In the majority of cases, the PH patient will in the first instance visit a GP when they become unwell. The GP will determine the best course of action for a patient after assessing their symptoms. One of the possible routes a GP can take thereafter is to refer the patient to a specialist consultant (or, far less frequently, a particular PH facility). At this point, the patient has a decision to make regarding whether their treatment is to be funded by the NHS or if they are going to fund their treatment privately (either via the use of their PMI policy if possessed by the patient, or by funding it personally (self-paying)). The decision to be treated privately may depend on many factors. The OFT patient

interviews suggest that an important factor is the wish to be treated quickly, avoiding NHS waiting times.<sup>28</sup>

- 3.7 PMI funded patients typically have either a corporate policy, obtained through their employer, or an individual policy, obtained directly from a PMI provider. Publicly available figures suggest that 69 per cent of PMI sales in 2010 were to corporate customers.<sup>29</sup>
- 3.8 Each PMI provider typically offers a series of different policies tailored to the needs of different customers. Each policy will list the PH facilities at which a policyholder is entitled to be treated. Most PMI funded patients are on a PMI network policy, the typical features of which are described in Box 8.1 in chapter 8.
- 3.9 If a patient does not have PMI cover, they can choose to fund their treatment themselves. This would involve ascertaining the cost of the treatment with a PH facility and paying both the hospital and the consultant fees (including the anaesthetist fee, if an anaesthetist is required) directly. In some instances, the PH facility may offer a 'package price' to the patient; this is an overall bundle price incorporating the hospital, consultant and anaesthetist fees. The proportion of PH patients that self-pay has fallen from approximately 18 per cent in 2004 to approximately 14 per cent in 2010. Laing and Buisson has indicated in its Healthcare Market Review 2010-11 that the proportion of patients who choose to self-pay is related to NHS waiting times – as NHS waiting times fall so does the number of patients who self-pay.<sup>30</sup>

## GPs

- 3.10 GPs act as the key interface between primary and secondary care.<sup>31</sup> In order for a patient to see a specialist consultant or unit at a facility

<sup>28</sup> OFT patient interviews, pages 21 and 24.

<sup>29</sup> Laing & Buisson, *Laing's Healthcare Market Review 2011-2012*, Table 3.12, page 200.

<sup>30</sup> Laing & Buisson, *Laing's Healthcare Market Review 2011-2012*, page 42.

<sup>31</sup> 'Primary care' refers to services provided by GP practices, dental practices, community pharmacies and high street optometrists. 'Secondary care' is usually delivered in hospitals or clinics and patients are usually referred to secondary care by their primary care provider.

(whether an NHS or a PH facility), a formal letter of referral from the patient's GP is normally required. Through this role of primary diagnosis and referral, GPs effectively act as the gateway by which patients access secondary care treatment.<sup>32</sup>

- 3.11 Previous research relating to the provision of publicly funded healthcare by DH has repeatedly found that GPs also play a key role in the provision of information to patients about their options regarding healthcare facilities, both NHS and PH, and regarding consultants.<sup>33</sup>
- 3.12 The OFT's research in this market study indicates that this finding is also relevant to the PH market. The OFT patient interviews and the OFT GP survey both indicate that patients place a great amount of trust in their GPs' opinions and recommendations.<sup>34</sup> GPs appear to be aware of this relationship of trust and their influence on patient choice. In the OFT GP survey, 74 per cent of GPs, when asked, thought that they were the most important influence on a patient's choice of facility and/or consultant.<sup>35</sup>

## Consultants

- 3.13 Consultants are specialist senior doctors<sup>36</sup> who typically base their work in hospitals and clinics.

<sup>32</sup> See OFT patient interviews, where the report also identified other ways that patients can enter the PH market. For example, a patient may discuss private treatment while visiting an NHS hospital and enter the PH market this way or the patient may contact the consultant and/or facility directly to discuss treatment.

<sup>33</sup> For instance, in 2009 DH found that around half of NHS patients offered a choice of hospital relied on their GP as a source of information, DH (2009) Report on the National Patient Choice Survey – March 2009 page 7. In total, GPs were mentioned by 49 per cent of the survey respondents compared to 33 per cent who used their own or family and friends past experiences, 7 per cent who mentioned a booklet about choice, and 6 per cent who used NHS Choices website.

<sup>34</sup> OFT patient interviews, pages 22 and 42.

<sup>35</sup> OFT GP survey, pages 26-27.

<sup>36</sup> This would include surgeons.

- 3.14 Since 1997, any doctor taking up an NHS consultant position is required to be included on the Specialist Register as held and maintained by the General Medical Council (GMC).<sup>37</sup> The rules for entry onto the Specialist Register are set out in legislation,<sup>38</sup> and include formal training in the relevant medical speciality leading to the award of a Certificate of Completion of Training (CCT) by a competent authority.<sup>39</sup>
- 3.15 In general, consultants working in PH also hold an NHS consultant position. This is due to a combination of two factors:
- PH providers' admission criteria (which must be met by a consultant in order to gain practicing privileges at a PH facility) usually include being on the relevant GMC Specialist Register and holding a substantive NHS consultant position.<sup>40</sup>
  - PMI providers' recognition criteria (which must be met in order to treat patients funded by PMI) generally require that a consultant holds a CCT, is entered onto the GMC Specialist Register and is (or once was) in a substantive NHS consultant position.
- 3.16 As noted by the OFT population report<sup>41</sup> – based on the most recent dataset available from 1992 – 84 per cent of consultants working in private practice also worked in the NHS, a further 15 per cent had worked in the NHS, and only one per cent of consultants in private practice had never worked in the NHS. Given both the PH providers' admission criteria and the PMI providers' recognition criteria, it is reasonable to estimate that a significant majority of consultants providing PH currently are also practicing NHS consultants.

<sup>37</sup> NHS consultants in position prior to 1997 may not be on the Specialist Register at present, although the GMC is looking into routes by which consultants in position prior to 1997 could be entered onto the Specialist Register.

<sup>38</sup> As set out in The European Specialist Medical Qualifications Order 1995 (SO3208) following a European directive facilitating the free movement of doctors.

<sup>39</sup> Currently the Postgraduate Medical Education and Training Board (PMETB) in the UK.

<sup>40</sup> As opposed to an honorary or temporary position.

<sup>41</sup> OFT population report, page 6.

- 3.17 Together with GPs, consultants appear to occupy a key position within the patient journey and have a significant role in the choices that patients make. This is evidenced by the manner in which PH patients tend to be referred to a consultant by their GP. Evidence submitted to the OFT indicates that around 85 per cent of GP referrals for PMI funded patients are to named consultants rather than 'open referrals' where the identity of the treating consultant is not specified.<sup>42</sup>
- 3.18 The OFT consultant survey suggests that consultants also play a key role in the selection of the PH facility where a patient is admitted. For instance, the survey shows that only a small minority of consultants offered their patients a choice between their main PH facility and another PH facility.<sup>43</sup>
- 3.19 Evidence submitted to the OFT suggests that even though consultants may hold admission privileges in a number of PH facilities, most tend to base the majority of their private work at one specific PH facility. For instance, the OFT consultant survey found that most consultants with admission privileges at two or more PH facilities still reported that they would treat between 71 and 100 per cent of their patients in their main PH facility over an average month.<sup>44</sup> As discussed in chapter 8, evidence indicates that consultants want to treat patients at PH facilities that are recognised by all PMI providers as this gives them the widest possible pool of PH patient business at one PH facility. This is known as the 'consultant drag' effect.

## PH providers

- 3.20 There are five main PH provider groups active in the UK, each of which owns a network of PH facilities located throughout the UK. These are: General Healthcare Group (GHG), which operates a number of PH

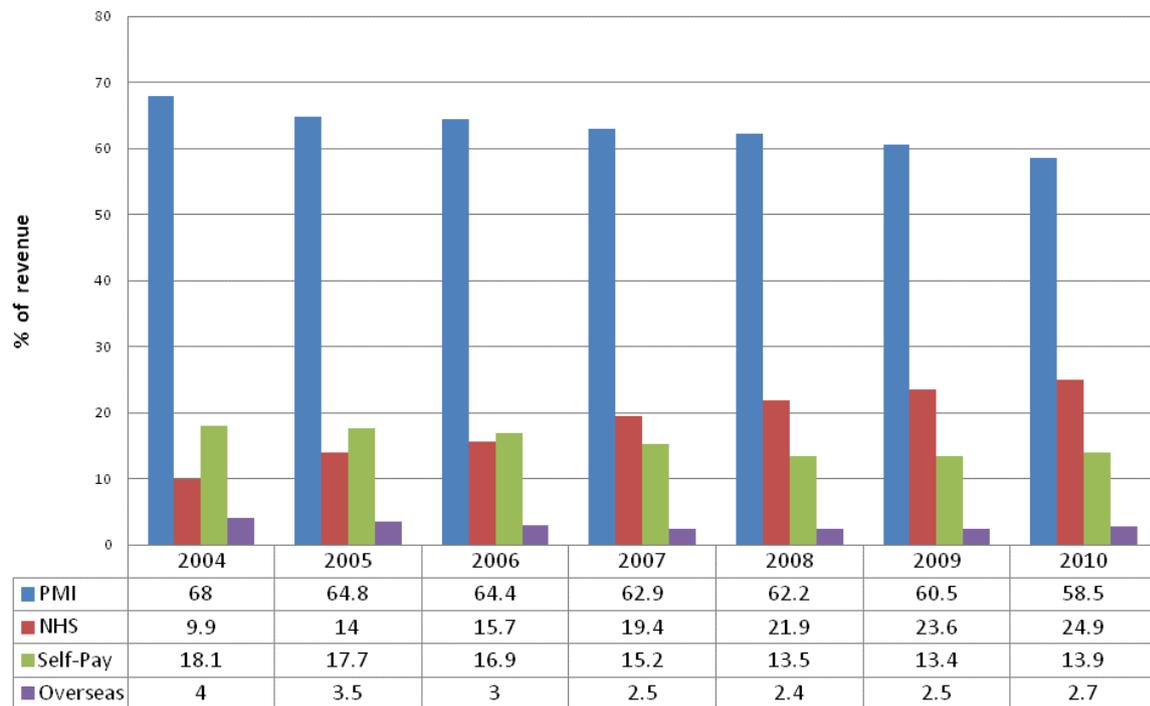
<sup>42</sup> In making an open referral, a GP may specify the PH facility/specialist unit (by addressing the referral letter to 'Dear Colleague' for instance) or, in regard to some PMI funded patients, filling out a referral form that specifies neither the consultant nor PH facility. For more discussion of this latter type of open referrals under PMI managed care initiatives, see paragraphs 5.84 and 5.91.

<sup>43</sup> OFT consultant survey, pages 53-4 (3.4.2).

<sup>44</sup> OFT consultant survey, page 58.

facilities through their subsidiary BMI, Spire Healthcare (Spire), Nuffield Health (Nuffield), HCA International (HCA) and Ramsay Health Care UK (Ramsay). These top five PH providers accounted for approximately 77 per cent of the PH market by revenue in 2010.<sup>45</sup> The market also includes smaller, independent PH facilities,<sup>46</sup> and NHS PPUs. The OFT considers further below how PH providers interact with PMI providers and compete.

**Figure 3.2: PH funding sources, UK estimates 2004-2010**



3.21 Publicly available sources<sup>47</sup> show that in 2010, PMI funded patients were the main source of revenue for PH providers, followed by NHS contracts, self-pay patients and overseas patients. These shares are illustrated by Figure 3.2 above.

<sup>45</sup> Data supplied by Laing & Buisson, *Laing's Healthcare Market Review 2011-2012*. The data excludes centrally procured ISTC activity and diagnostics for the NHS provided by specialist diagnostic providers.

<sup>46</sup> For instance, The London Clinic, The Horder Centre and The Hospital of St John & St Elizabeth.

<sup>47</sup> Laing & Buisson, *Laing's Healthcare Market Review 2011-2012*, page 43, although this includes revenue from NHS funded patient who sought treatment from Independent Sector Treatment Centres (ISTCs see paragraph 3.28). Publicly funded patients treated in PH facilities are not within the scope of this study.

- 3.22 PH providers may have a range of PH facilities within their portfolio, from full service facilities,<sup>48</sup> to single line or specialist facilities, such as ophthalmology clinics or scanning facilities.
- 3.23 The larger PH providers all own a number of full service facilities which offer treatments across a wide range of specialities. Full service facilities will, therefore, typically have consultation rooms, theatres, inpatient beds and day case beds and will offer inpatient, outpatient and day case procedures.
- 3.24 Due to medical and technological advances over recent years, there has been a reduction in the volume of procedures conducted in an inpatient setting and an increase in the number of procedures that can be carried out within a day case setting. Latest estimates from the Acute Market Monitoring Survey (AMMS), reported in Laing & Buisson, *Laing's Healthcare Market Review 2010-2011*, show that 63 per cent of procedures are carried out in a day case setting at full service facilities and this figure could be as high as 70 per cent if day case only facilities<sup>49</sup> are included.<sup>50</sup>

### Interaction with the NHS

- 3.25 The NHS interacts with the PH market in various ways, as a provider of healthcare, a participant in the PH markets through a number of PPUs, as a procurer of PH services and through any limits it may place on consultants to practice in the PH market.
- 3.26 The NHS is a provider of healthcare services free at the point of use and so may offer a degree of constraint on the PH market, especially in regard to affecting the demand for PH amongst self-pay patients.<sup>51</sup>

<sup>48</sup> Full service facilities are those that provide a wide range of treatments and procedures. This includes outpatient, inpatient and day case procedures.

<sup>49</sup> These are facilities that only carry out day case procedures, which are procedures that will require the patient to rest in a bed but do not require an overnight stay.

<sup>50</sup> See Laing & Buisson, *Laing's Healthcare Market Review 2010-2011* page 123.

<sup>51</sup> Laing & Buisson, *Laing's Healthcare Market Review 2010-11*, page 44 states that 'hospitals' self-pay share has dropped by around a third in the last five years, as falling NHS waiting lists have made 'queue jumping' less important for potential private patients'.

However, as set out in Chapter 4, the OFT considers it unlikely that the NHS as a whole is part of the relevant product market.<sup>52</sup>

- 3.27 The NHS is also a participant in the PH market, with just over 70 dedicated PPU's and a number of private beds in NHS facilities.
- 3.28 Furthermore, the NHS is a procurer of PH services, as publicly funded patients seek treatments from PH facilities, such as Independent Sector Treatment Centres (ISTCs)<sup>53</sup> and via a series of patient choice reforms<sup>54</sup> culminating in the 'Any Willing Provider' (AWP) initiative.<sup>55</sup>
- 3.29 Finally, the NHS controls the availability of NHS employed consultants to the PH market. The OFT consultant survey showed that a consultant's NHS hospital may impose a constraint on the amount of PH work that the consultant could undertake in a given week or month. However, the OFT notes in this context that 27 per cent of consultants indicated that there were no such constraints on their PH practice and a further 28 per cent of consultants did not know whether there were any constraints on the amount of PH work they could undertake.<sup>56</sup>

<sup>52</sup> This is considered further at paragraph 4.36 – 4.41 in the next chapter.

<sup>53</sup> In 2002, the government chose to procure additional elective surgery capacity centrally from the independent sector through the ISTC programme, as part of an overall NHS strategy to improve the delivery of elective surgery by making large-scale reductions in waiting times. ISTCs are privately owned, but are free at point of use like other NHS facilities. Many ISTCs were new builds (sometimes on NHS facilities), although some were developed from existing NHS or PH facilities. Notable ISTC providers include Care UK and Ramsay Health Care UK.

<sup>54</sup> From the early 2000s onwards, NHS patients have been afforded greater choice over where to be treated. Major milestones within such reforms include: 2004, when NHS patients waiting for a range of elective surgery types were first offered a choice of hospitals by NHS managers, 2006, when patients were given the right to choose between at least four hospitals and then, in 2009, when patient choice of hospital became a legal right under the NHS Constitution. The OFT notes that many of these reforms only apply to the NHS in England, rather than in Scotland, Wales or Northern Ireland.

<sup>55</sup> As set out in the OFT's Private Healthcare Market Study Scoping Paper published in December 2010, and described in Chapter 2, NHS purchasing of PH is not directly within the scope of this market study.

<sup>56</sup> OFT consultant survey, pages 49-51.

3.30 The OFT briefly discusses the role of, and interactions with, the NHS within the PH market further at chapter 4. In particular, the OFT considers further the extent to which NHS facilities exercise a competitive constraint on the behaviour of other players in the PH market.

### PMI providers

3.31 For PMI funded patients, the PMI provider will usually have an agreement in place with the PH provider to pay the cost of the treatment directly to the PH provider. The PMI provider will also reimburse the consultant for their fees on behalf of the PMI funded patient.

3.32 The PMI provider may pay the consultant costs incurred in full or pay the costs up to a certain limit,<sup>57</sup> with the PMI funded patient sometimes paying shortfalls (when treatment costs unexpectedly exceed the PMI limit) or top-up fees (when an additional fee in excess of the limit is agreed between the patient and consultant before the treatment starts) directly to the consultant.

3.33 As discussed above, whilst it is typically the GP and the consultant that are key in determining where the patient is treated and by whom, in some instances the PMI provider also plays a role.<sup>58</sup> For example, albeit less frequently, the PMI provider may also help the patient choose a PH facility and/or consultant in the event that the GP provides the patient with an 'open referral' letter. Furthermore, as part of 'managed care', the PMI provider may play a more active role in the patient's care including restrictions on the choice of PH facility or treating consultant as part of the patient's PMI policy. This role is examined at paragraphs 5.77 to 5.81 below.

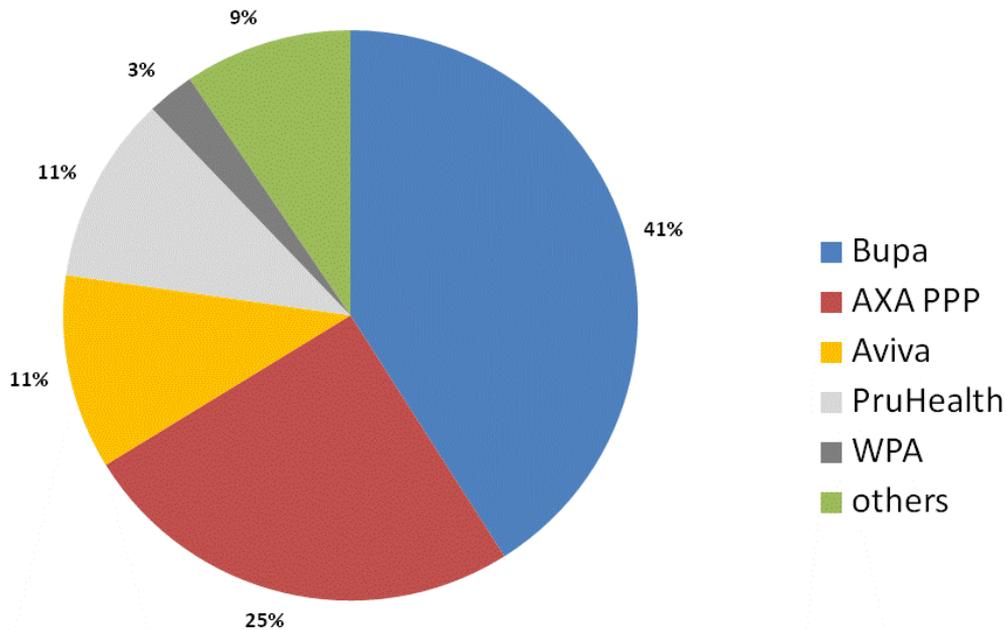
3.34 There are five main PMI providers active in the UK. These are Bupa, AXA PPP, Aviva, PruHealth (which owns Standard Life Healthcare) and WPA.

<sup>57</sup> This is usually set out in a fee schedule operated by most PMI providers. Bupa's benefit maxima is often regarded as the industry standard. AXA PPP do not use a fee schedule, instead reimbursing to 'customary levels'.

<sup>58</sup> OFT patient interviews, page 22.

Together, these five PMI providers account for approximately 91 per cent of the revenue from PMI sales 'subscription income'.<sup>59</sup>

**Figure 3.3: PMI shares of subscription income 2010<sup>60</sup>**



3.35 The subscription shares of the top five PMI providers have been relatively stable over the period from 2005 to 2010, with their combined shares increasing by six percentage points (from 85 per cent to 91 per cent). Over the period from 2006 to 2008, the number of PMI policyholders has also remained relatively stable, increasing by 33,000 policyholders (from 3,574,000 policyholders in 2006 to 3,607,000 in 2008). From 2008 to 2010 the number of PMI policyholders has fallen to 3,238,000.

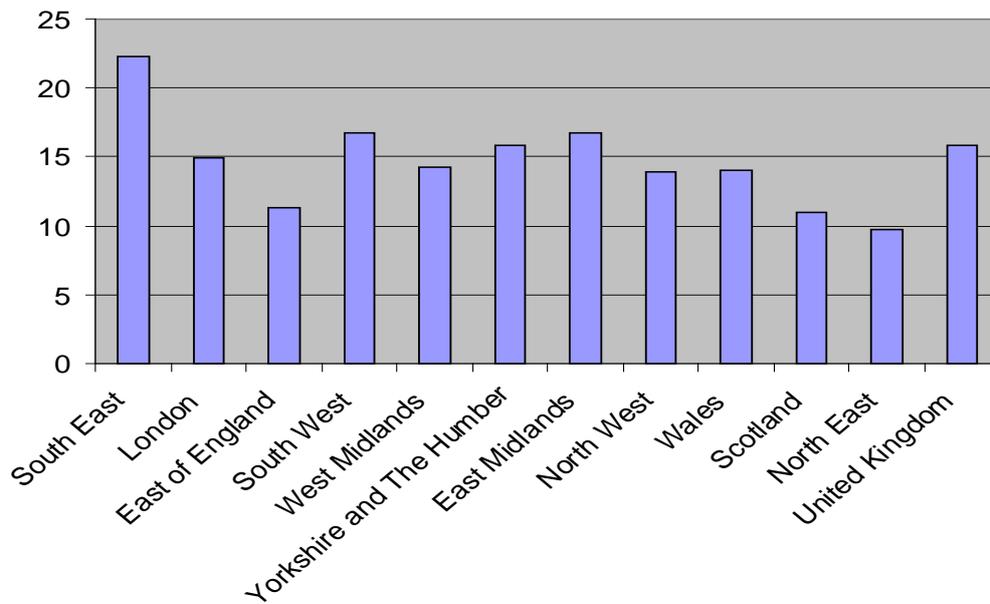
3.36 PMI penetration varies by region, as Figure 3.4 below shows. The South East of England has the highest PMI penetration with 22.3 per cent of the population in this region covered by PMI. The South West of England and the East Midlands both have a PMI penetration of 16.7 per cent. The North East of England and Scotland have the lowest PMI penetration, with 9.7 per cent and 11 per cent of the population covered by PMI and

<sup>59</sup> *Laing's Healthcare Market Review 2011-2012*, Table 3.14, page 206.

<sup>60</sup> *Ibid.*

self-insured medical schemes respectively. Figure 3.4 below does not include PMI penetration for Northern Ireland as this figure was not presented in the data. The latest figures for Northern Ireland are present in Laing's Healthcare Market Review 2011-12 and shows that in 2006 PMI penetration was 7.5 per cent in Northern Ireland.

**Figure 3.4: Geographic breakdown of PMI penetration 2010<sup>61</sup>**



<sup>61</sup> Proportion of Population Covered by PMI & self-insured medical expenses schemes (PMI Penetration) 2010 (%) Source: Target Group Index, Kantar Media, Quarter 2 (January 2010-December 2010); in Keynote, *Private Healthcare Market Report*, 2011.

## 4 MARKET DEFINITION

### Introduction

- 4.1 It is widely acknowledged that assessing the likely PH product and geographic market definitions is a difficult task. This is due to two main characteristics of the PH sector:
- Heterogeneity of patients and PH facilities: patients' preferences, such as willingness to pay or willingness to travel to different PH facilities may differ between patients, while facility characteristics can differ by, for example, location or quality of service.
  - Lack of PH patient treatment price-sensitivity: the majority of patients fund their treatment through PMI, and are therefore insensitive to immediate increases in the price of treatment. Therefore, any market definition technique that relies on the patient's reaction to price is unlikely to capture the market accurately.<sup>62</sup>
- 4.2 The OFT has not striven in this market study to arrive at conclusions on the definition of the relevant product and geographic markets concerned, as the OFT does not consider this to be necessary for an examination of the features of the PH market for the purposes of considering whether to make a MIR as described in the OFT's Market Investigation References guidance.<sup>63</sup>

<sup>62</sup> Given some of the theoretical and methodological difficulties in defining markets for private healthcare, the OFT commissioned the economic consultants Oxera to undertake a literature review and assessment of the techniques for defining markets in private healthcare so that this may be of use for future competition analysis, see Oxera, *Techniques for defining markets for private healthcare in the UK*, 2011. The findings of this report are reviewed in this chapter.

<sup>63</sup> *Market Investigation References – Guidance about the making of references under Part 4 of the Enterprise Act*, March 2006, paragraph 4.8. 'In making a market investigation reference to the CC, the OFT must specify the goods or services for whose supply or acquisition competition is adversely affected. This will require some consideration of the definition of the relevant market.' The guidance provides further that '[t]he effects on competition of some feature may be clear enough that firm conclusions on the definition of the relevant market by the OFT are unnecessary'. See: [www.of.gov.uk/shared\\_of/business\\_leaflets/enterprise\\_act/of511.pdf](http://www.of.gov.uk/shared_of/business_leaflets/enterprise_act/of511.pdf)

- 4.3 Rather, the OFT has sought to assess the relevant competitive constraints operating on the supply of PH that form the basis of likely product and geographic market definitions.
- 4.4 In line with previous OFT and CC merger decisions, the OFT remains of the view that the product market is likely to be the provision of privately funded healthcare services. These are provided to patients via private facilities/clinics including PPUs, through the services of consultants and medical professionals who work within these facilities.<sup>64</sup>
- 4.5 In terms of extending the product market, the competitive constraint provided by PPUs varies based on the size of the PPU, the reputation of the NHS facility it is attached to, and the support it receives from local consultants. In some local markets, PPUs are likely to form part of the relevant product market.
- 4.6 The geographic markets appear to be national and local in nature. The OFT also continues to consider that there may be some regional aspects to competition, mainly for corporate PMI policyholders who are based in particular regions. For the purposes of this market study local markets have been defined using 30-minute drive time isochrones, centred on PH facilities.
- 4.7 As part of this market study, the OFT commissioned the economic consultants Oxera to produce a report assessing the different techniques for defining markets for PH in the UK (OFT market definition report).<sup>65</sup> While the OFT market definition report was commissioned as part of this market study, this report has wider value for the OFT, CC and other bodies in any future studies of this market and in any future merger cases. This report is mainly focused on local geographic market

<sup>64</sup> Previous OFT and CC merger decisions: (i) Completed acquisition by General Healthcare Group of control of four Abbey hospitals and de facto control over Transform Holdings Limited previously part of the Covenant Healthcare Group, October 2010; (ii) Completed acquisition by Spire Healthcare Limited of Classic Hospitals Group Limited, July 2008; (iii) Completed acquisition by General Healthcare Group of assets of Nuffield Facilities, May 2008; and (iv) British United Provident Association Limited and Community Hospitals Group Plc: A report on the proposed merger; and British United Provident Association Limited, Salomon International LLC and Community Hospitals Group Plc; and Salomon International LLC and Community Hospitals Group Plc: A report on the existing mergers, December 2000.

<sup>65</sup> OFT market definition report.

definition because Oxera found that much of the academic literature and case law on PH market definition has focused on quantifying the local geographic element of market definition.

- 4.8 The OFT market definition report has found that there are a number of ways to define local PH markets, each of which may be appropriate in different circumstances. A brief discussion of the appropriateness of these different techniques for defining local PH markets can be found in the geographic market section of this chapter.
- 4.9 This chapter summarises the previous relevant market definitions used by the OFT and CC in recent merger cases, the analysis presented in the OFT market definition report, the related evidence received in the course of this study, the consultation responses received and includes an assessment of the relevant competitive constraints that operate in the provision of PH. This chapter has two sections, these are:
- product market
  - geographic market.

## **Product market**

- 4.10 In the consultation document, the OFT considered that from a PH patient's perspective, whether they are self-paying or PMI funded, the product market is likely to be focused on particular treatments as, from the demand side, treatments or procedures are not usually substitutable. For example, a patient that requires a hip replacement could not substitute this procedure for a knee replacement. However, as noted in the OFT market definition report, for a particular treatment there may be several approaches that are to some extent substitutable, such as different types of hip replacement.<sup>66</sup> Treatments are also prescribed by a consultant and, as discussed in the next chapter, patients tend to place considerable trust in their consultant's recommendations.
- 4.11 In terms of supply side substitutes, consultation rooms and theatres can be used to perform a wide variety of procedures and treatments, provided that the consultants needed to perform these practice from the

<sup>66</sup> For example a hip replacement can be carried out with or without the use of cement.

PH facility or that the PH facility could relatively quickly attract the necessary consultants. This also relies on the PH facility having, or being able to acquire relatively quickly, any specialist equipment needed, such as a MRI scanner. This is supported by the OFT market definition report, which states that the competitive constraint provided by one PH facility on another is likely to relate to a group of treatments rather than a single type of treatment.<sup>67</sup>

- 4.12 The OFT remains of the view that the starting point for considering product market definition is the provision of a wide range of treatments by a PH facility. It is however noted in the OFT market definition report that not all treatments will be capable of supply side substitution such that they will be part of a single product market range. Some PH facilities may be unable to quickly offer certain treatments that require particular consultants and equipment to perform them.
- 4.13 The OFT, in its consultation document, considered that in terms of consultants, there is unlikely to be significant supply side substitution between consultants of different specialities due to the expertise and experience necessary to perform clinical procedures. For example, an anaesthetist will not be a supply side substitute for a cardiothoracic surgeon.
- 4.14 As stated in chapter 3, consultants are required to be included on the Specialist Register as held and maintained by the GMC. Entry onto the Specialist Register requires formal training in the relevant medical speciality, such as anaesthesia, ophthalmology and neurosurgery, leading to the award of a Certificate of Completion of Training (CCT) by a competent authority. The OFT remains of the view that consultant specialities are therefore likely to be in separate product markets. It is however noted that for some treatments, the consultant product market may be narrower than the consultant speciality, where consultant sub-specialities may have developed to deal with those treatments. For certain other treatments, the consultant product market may be slightly wider than the consultant speciality where treatments may overlap between two or more specialities. However, for the purposes of this market study, the OFT has not considered it necessary to examine this question further.

<sup>67</sup> OFT market definition report.

- 4.15 In the particular case of anaesthetists there is unlikely to be any supply side substitution given the nature of the speciality. Anaesthetists have undergone postgraduate specialist training in anaesthesia, intensive care medicine and pain medicine, which takes approximately seven years to complete.

#### Previous definitions used by the OFT and CC

- 4.16 The report published by the CC on the proposed merger between Bupa and CHG in 2000<sup>68</sup> considered the treatments that are typically covered by PMI to help define the product market for PH, whilst noting in the report that the relevant product market related to all PH patients, including self-pay patients. The report stated that 'acute facilities provide a wide spectrum of treatment services which accord closely with the range of treatments covered by PMI.'<sup>69</sup> The CC concluded that other PH facilities and clinics that are more specialised and typically deal with procedures that are not normally covered by PMI or offered by most PH acute facilities, such as cosmetic surgery and pregnancy termination clinics, are in separate product markets. This approach to product market definition has been applied by the OFT, in subsequent merger cases, such as the GHG/Nuffield merger in 2008.<sup>70</sup>

<sup>68</sup> British United Provident Association Limited and Community Hospitals Group Plc: A report on the proposed merger; and British United Provident Association Limited, Salomon International LLC and Community Hospitals Group Plc; and Salomon International LLC and Community Hospitals Group Plc: A report on the existing mergers, December 2000, available at: [www.competition-commission.org.uk/rep\\_pub/reports/2000/449bupa.htm#summary](http://www.competition-commission.org.uk/rep_pub/reports/2000/449bupa.htm#summary)

<sup>69</sup> See British United Provident Association Limited and Community Hospitals Group Plc: A report on the proposed merger; and British United Provident Association Limited, Salomon International LLC and Community Hospitals Group Plc; and Salomon International LLC and Community Hospitals Group Plc: A report on the existing mergers, December 2000, available at: [www.competition-commission.org.uk/rep\\_pub/reports/2000/fulltext/449c4.pdf](http://www.competition-commission.org.uk/rep_pub/reports/2000/fulltext/449c4.pdf) page 89.

<sup>70</sup> Completed acquisition by General Healthcare Group of assets of Nuffield Facilities, May 2008, page 6. Available at: [www.of.gov.uk/shared\\_of/mergers\\_ea02/2008/GHG.pdf](http://www.of.gov.uk/shared_of/mergers_ea02/2008/GHG.pdf) The report also noted that there is evidence that PPU provide a weaker constraint on private facilities compared to other private facilities.

4.17 The CC and OFT have also noted in merger cases that PPUs<sup>71</sup> which provide a wide range of medical treatments and are available to PH patients on a full time basis should also be included in the relevant product market. The OFT noted that PPUs should be included in the relevant product market because they typically offered similar services to other PH facilities and were 'often included on the networks of PMI providers'.<sup>72</sup>

### Submissions made during this market study

4.18 Relevant submissions from PH and PMI providers in the context of the market study and most consultation responses did not provide views on the types of treatments that should be included in the product market definition.<sup>73</sup> However, they did provide detailed views on whether PPUs act as a competitive constraint on PH providers and, therefore, whether those facilities should be included in the relevant product market.

4.19 In particular, PH providers submitted during the market study that PPUs do act as a competitive constraint on PH facilities and that this constraint is set to increase if the private patient cap<sup>74</sup> is removed.

4.20 In this context, a number of PH providers flagged what were perceived to be the unfair competitive advantages enjoyed by PPUs, including potential access to existing NHS infrastructure, facilities and staff. These concerns were repeated by a number of the larger PH providers in their consultation responses. This is discussed further in chapter 9.

<sup>71</sup> There are over 70 PPUs across the UK. Laing & Buisson state that nine PPUs are managed by PH providers (also known as 'partnering'). This is discussed further in chapter 6.

<sup>72</sup> See Completed acquisition by General Healthcare Group of assets of Nuffield Facilities, May 2008, page 6. Available at: [www.ofg.gov.uk/shared\\_ofg/mergers\\_ea02/2008/GHG.pdf](http://www.ofg.gov.uk/shared_ofg/mergers_ea02/2008/GHG.pdf)

<sup>73</sup> The OFT received a response to the consultation from one of the larger PMI providers which states that it is more appropriate for the OFT to examine a narrow cluster of treatments rather than a broad range of treatments.

<sup>74</sup> The private patient cap applies to NHS foundation trusts, and it places a limit on the revenue these trusts can derive from private charges. The limit is set at the proportion of the total income that the trust derived from private charges in the base year, which is 2002-3. <http://www.nhsconfed.org/Training/FoundationTrust/Workstreams/Finance/Pages/PrivPatientIncomeCap.aspx>

- 4.21 PH providers also raised concerns during the market study that NHS Trusts appear to be imposing restrictions on NHS consultants, who also practice in the PH market, that limit the supply of consultants to PH providers in favour of their PPUs.<sup>75</sup>
- 4.22 However, some PMI providers do not regard most PPUs as a competitive constraint on, or demand substitutes for, other PH providers in the market. A PMI provider commented that most PPUs tend to be very small (with few beds) and, therefore, do not provide a credible alternative in terms of scale to other PH facilities. Capacity is important to PMI providers because policyholders value PMI cover that enables them to be treated quickly, which may only be possible if there are beds available in local PH facilities.
- 4.23 One PMI provider that has launched a PMI policy based around patients being treated in PPUs in exchange for a lower premium has reported that this policy has a low uptake. Further, whilst the PMI providers state that their recognition criteria<sup>76</sup> are generally the same for PPUs as for other PH providers,<sup>77</sup> it remains apparent that relatively fewer PPUs are recognised by PMI providers on their networks compared to other PH providers. PPUs themselves have reported that they have difficulty in securing PMI provider recognition. This is supported by evidence that PPUs are comparatively underrepresented on the major PMI providers' networks.<sup>78</sup>

<sup>75</sup> A response to the consultation from a PPU has stated that consultants are free to determine where to treat private patients outside of their NHS hours and they can see no mechanism whereby the NHS could coerce consultants to undertake their private practice in a PPU over another PH facility. The OFT has not considered this point in detail and therefore has not established whether there are restrictions imposed on NHS consultants.

<sup>76</sup> PMI providers have a set of criteria that PH providers must satisfy. The criteria relates to factors such as quality standards and price.

<sup>77</sup> Although one PMI provider states that it expects PPU prices to be at least 15 per cent cheaper than the prices of other private facilities in the same geographical area.

<sup>78</sup> Laing & Buisson, *Laing's Healthcare Market Review 2011-2012*, page 57 shows that 27 out of 73 PPUs are not listed on either the Bupa or the AXA PPP standard hospital networks, and only 15 of the 73 are listed on both Bupa and AXA PPP standard hospital networks.

- 4.24 The OFT notes that some PPUs do, however, seem to compete effectively with other PH providers and are considered by PMI providers to be viable alternatives. These PPUs tend to be based in London or other large metropolitan areas and attached to NHS facilities with strong established reputations and/or teaching hospital status. Eight of the top 10 NHS trusts with the highest private patient revenue are based in central London.<sup>79</sup>
- 4.25 As discussed in chapter 3, consultants will often choose the PH facility at which they treat their patients. The OFT, therefore, also considered consultants' views as to whether PPUs act as a competitive constraint on other PH providers. The OFT consultant survey found that just under half of the 400 consultants surveyed preferred to work from a privately owned PH facility rather than a PPU. Only 17 per cent of the consultants surveyed stated a preference for being based primarily in NHS facilities that treat PH patients.<sup>80</sup>
- 4.26 The survey also found that a consultant's main PH facility is unlikely to be a PPU. Of those respondents that treated PH patients in one facility only, 78 per cent reported that this PH facility was not a PPU.<sup>81</sup> This does not preclude, however, that a consultant will also practice from a second PH facility which may be a PPU.
- 4.27 From a consultant's perspective, the OFT, in the consultation document, suggested it would appear that PPUs provide only a limited competitive constraint on other PH providers. It may be the case that those PPUs that have support from local consultants may provide a greater competitive constraint on other PH providers.
- 4.28 The OFT also received submissions from a small number of PPUs during the course of the market study regarding how they compete with other PH providers in the PH market. PPUs pointed out that the first duty of

<sup>79</sup> Laing & Buisson *Laing's Healthcare Market Review 2011-2012*, page 88.

<sup>80</sup> OFT consultant survey, pages 51-52, where most of the respondents did not have a preference.

<sup>81</sup> OFT consultant survey pages 57-59. Of those who treated patients in two private facilities, only 11 per cent reported that their main facility was a PPU and 28 per cent indicated that their second facility was a PPU.

care of the NHS facility to which the PPU is attached is to NHS patients, and that PPU beds may be given to NHS patients if needed. Further, some PPUs reported that their NHS Trust often devotes very few resources (managerial and financial) to the PPU. However, the OFT notes that this current situation may change following the Health and Social Care Bill receiving Royal Assent.

- 4.29 The current pattern of competitive constraint provided by PPUs may also be affected by partnering arrangements between NHS Trusts and PH providers.<sup>82</sup> It is likely that the competitive constraint offered by some PPUs that have partnering arrangements with the larger PH providers will be increased as the PPU may benefit from the PH market expertise of the PH providers, such as the established relationships between the PH and PMI providers. The PPU may also benefit from the established, national, brands of the larger PH providers.<sup>83</sup>
- 4.30 In the consultation document, the OFT considered that the degree of competitive constraint provided by individual PPUs varies. It appears that those PPUs that belong to NHS Trusts with the highest annual revenues from PH patients experience strong, and growing, demand – acting as a competitive constraint, therefore, on other PH providers - whilst other PPUs have generally experienced weaker demand.<sup>84</sup> The OFT believes that this differential is a result of the strong, established, international reputation of some of the NHS Trusts to which the PPUs are attached and the support from local consultants, which results in demand from self-pay and international PH patients as well as PMI funded patients.
- 4.31 Consultation responses from the PH and PMI providers expressed varying views on the OFT's analysis of the competitive constraint

<sup>82</sup> These partnering arrangements relate to PH providers having contracts in place to manage and operate the NHS PPU. As discussed in chapter 6, the OFT is aware of 10 partnering arrangements.

<sup>83</sup> However, PPU partnering may also have an impact on concentration in local markets. This is discussed in chapter 6.

<sup>84</sup> Laing & Buisson, *Laing's Healthcare Review 2011-2012*, page 89. In 2009/2010, latest figures show that the NHS trusts with the highest annual revenues from treating private patients increased their combined private patient revenues by 5.4 per cent, compared with a fall (down 7.9 per cent) in combined revenues for all other trusts.

offered by PPUs on other PH providers. While a few PMI providers agree with the OFT's view, one PMI provider has stated that PPUs offer little constraint on other PH providers and the presumption that PPUs are within the product market may lead to incorrect assessments of the number of competitors in any future merger investigations. A couple of the smaller PH providers (including a PPU) stated in their consultation responses that the competitive constraint provided by PPUs on other PH providers was limited.

- 4.32 A number of the PH providers have commented in their consultation responses that not only do the PPUs compete in the market but that the OFT has underestimated their competitive constraint, which these PH providers state is set to increase once barriers to their expansion are removed, such as an increase to the private patient cap. One PH provider has also commented that it is not only the PPUs in London and other large metropolitan areas that are viable alternatives to other local PH providers.
- 4.33 Laing & Buisson show that the PPUs have a combined market share of just fewer than eight per cent and this market share has been falling since 1997.<sup>85</sup> It is not apparent, therefore, that the PPUs do provide a greater competitive constraint than suggested by the OFT. Also, as discussed at paragraphs 4.25-4.27, from a consultant's perspective, it would appear that PPUs provide a limited competitive constraint on other PH providers.
- 4.34 In addition, the OFT does not have evidence that suggests that the competitive constraint offered by PPUs will increase following an increase to the private patient cap. The DH impact assessment for the Health and Social Care bill<sup>86</sup> states that most Foundation Trusts operated at a level significantly below their private patient income cap and that the evidence indicates that many Foundation Trusts will not automatically make use of any ability to earn private income offered to them.

<sup>85</sup> Laing & Buisson, *Laing's Healthcare Market Review 2011-2012*.

<sup>86</sup> Health and Social Care Bill 2011: Impact Assessments. Available at: [www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_129917.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_129917.pdf)

4.35 Therefore the OFT's view remains that it is likely that PPU's do form part of the relevant product market, although their competitive constraint on other PH providers varies case by case.

4.36 Finally, some PH providers argued that the NHS as a whole, by providing a free substitute to PH, is a relevant competitive constraint. In its consultation document, the OFT noted that this view is inconsistent with the 2008 merger decision regarding the acquisition by General Healthcare Group of assets of Nuffield Facilities, which quoted from the Bupa/CHG merger decision by the CC that the willingness of customers to pay an extra charge for PH indicated that free services fell into a separate market.<sup>87</sup>

4.37 This view was reiterated during the consultation. Responses from some of the larger PH providers suggested that the OFT had not properly considered the competitive constraint that the NHS as a whole places on PH providers. A few PH providers pointed to PMI providers encouraging their policyholders to use the NHS instead of claiming on their PMI policies by:

- offering cash incentives
- limiting the amount that policyholders can claim
- offering policyholders the option of including the six-week rule<sup>88</sup> in their policies

as evidence that the PMI providers see the NHS as a whole as a viable alternative to PH providers.

4.38 Previous submissions from PH providers have set out how they differentiate themselves from NHS provision in terms of offering greater convenience for patients, more choice regarding appointment times and ensuring that the patient sees the same consultant throughout their treatment, to name a few.

<sup>87</sup> Completed acquisition by General Healthcare Group of assets of Nuffield Facilities, May 2008, pg 5. Available at: [www.oft.gov.uk/shared\\_oft/mergers\\_ea02/2008/GHG.pdf](http://www.oft.gov.uk/shared_oft/mergers_ea02/2008/GHG.pdf)

<sup>88</sup> The six-week rule is an option that can be added to PMI policies whereby policyholders are typically treated in the NHS if treatment is available in the NHS within six weeks.

- 4.39 There are also clear examples from OFT<sup>89</sup> and EU merger investigations of the NHS as a whole not being included in the relevant product market. The European Commission's decision in the Capio case<sup>90</sup> found that there are a number of differences between private and public health care services. The decision noted that '[p]rivate acute hospitals also differentiate themselves from public acute hospitals in terms of the overall patient experience, waiting lists, clinical outcomes and physical comfort [...] there are good reasons to define a separate market for private acute general hospitals for the UK'.
- 4.40 The OFT did not further investigate whether the NHS is part of the relevant market as it was considered unnecessary for a first phase enquiry, particularly in light of the analysis in previous OFT and merger cases. However, the CC may wish to examine this further as part of its more detailed investigation. Therefore, the OFT remains of the view that the NHS as a whole is unlikely to be part of the relevant product market.
- 4.41 The OFT does however note that the NHS may, as explained in chapter 3, provide some constraint on the PH market as NHS performance is an important determinant of demand for acute PH, particularly for self-pay patients who make a decision whether or not to pay for their treatment. Also, the OFT acknowledges that demand for PMI policies may be impacted by the performance of the NHS as a whole as patients may only purchase PMI cover if it represents value when compared to the NHS free service in their local area. However, this does not alter the OFT's view that the NHS as a whole is unlikely to be part of the product market.

### Conclusion on product market

- 4.42 On the basis of the evidence submitted, a review of previous OFT, EU and CC merger decisions and having given careful consideration to

<sup>89</sup> Completed acquisition by General Healthcare Group of control of four Abbey hospitals and de facto control over Transform Holdings Limited previously part of the Covenant Healthcare Group, October 2010; Completed acquisition by Spire Healthcare Limited of Classic Hospitals Group Limited, July 2008; and Completed acquisition by General Healthcare Group of assets of Nuffield Facilities, May 2008.

<sup>90</sup> COMP/M.4367 Apax Partners Worldwide LLP (APW), Nordic Capital Fund VI, Apax Partners SA (APSA) and Capio AB, European Commission, March 2007.

consultation responses, the OFT remains of the view that the relevant product market is likely to be the provision of privately funded healthcare services. These are provided to patients via private facilities/clinics including PPU's, through the services of consultants and other medical and clinical professionals who work within these facilities. PPU's that are attached to NHS trusts that have strong reputations and PPU's that have support from local consultants are more likely to provide a competitive constraint on other PH providers. In line with previous OFT and EU merger decisions, the OFT has not included the NHS as a whole in the product market.

- 4.43 The OFT also considers that consultant specialities are likely to be in separate product markets.

### **Geographic market**

- 4.44 Relevant geographic markets may be both national and local in scope. Competition appears to take place at the national level between the PH providers in their contractual relations with PMI providers. There are national negotiations between PH and PMI providers to agree national prices for treatments and procedures and to agree the PH provider's facilities that will be included on the PMI provider's networks. At the same time competition between individual PH providers takes place at a local level to attract consultants to their PH facilities, whilst PH patients also typically prefer to be treated close to home.
- 4.45 The OFT considers that, while there is a national dimension to competition, competitive constraints on PH provision are likely to be predominately local. This is because while there may be national negotiations, the OFT considers that competitive constraints on PH providers arise predominately from patients' need to access local hospitals. In order to provide to these patients, PMI providers therefore appear to need to access local hospitals. Local competitive constraints may collectively influence national price setting during the negotiations between the PH and PMI providers.

### **Previous definitions used by the OFT and CC**

- 4.46 Geographic market definition in relation to the PH sector has previously been considered by both the OFT and the CC. The CC has stated that

'there are both local and national market influences' that are relevant to the appropriate geographic market definition.<sup>91</sup>

4.47 In terms of the relevant local market definition, the OFT's approach in merger cases had been based on a 30-minute drive time analysis using isochrones centred on PH facilities.<sup>92</sup> The CC considered this to be appropriate, but stipulated that there were exceptions where the catchment area should be wider, such as in rural areas. The CC also considered that, for corporate PMI policyholders, there could be regional aspects as some PMI cover may be regionally based.

4.48 In the Spire/Classic merger analysis conducted by the OFT in 2008,<sup>93</sup> postcode analysis was also used in conjunction with 30-minute drive times.<sup>94</sup> The OFT assessed the extent to which the parties' PH facilities overlap within 30-minute drive time isochrones. The parties also identified catchment areas that account for 80 per cent of the discharged patients from the parties' facilities. The OFT considered that both approaches can be useful indicators of the overlap in the catchment areas of PH facilities. However, both were noted to have limitations.<sup>95</sup>

4.49 The OFT, in its consultation document, suggested that the starting point for considering the relevant geographic markets is that there are both national and local geographic markets and that there may also be some regional elements to competition.

<sup>91</sup> British United Provident Association Limited, Salomon International LLC and Community Facilities Group Plc; and Salomon International LLC and Community Facilities Group Plc: A report on the existing mergers, December 2000, pg 103, available at: [www.competition-commission.org.uk/rep\\_pub/reports/2000/fulltext/449c4.pdf](http://www.competition-commission.org.uk/rep_pub/reports/2000/fulltext/449c4.pdf)

<sup>92</sup> This was expected to capture around 80 per cent of the patients for that facility.

<sup>93</sup> Completed acquisition by Spire Healthcare Limited of Classic Hospitals Group Limited, 2008, available at: [www.of.gov.uk/shared\\_of/mergers\\_ea02/2008/Spire.pdf](http://www.of.gov.uk/shared_of/mergers_ea02/2008/Spire.pdf)

<sup>94</sup> The analysis was provided by one of the parties.

<sup>95</sup> The OFT market definition report also discusses the limitations of catchment area analysis.

## Submissions made during this market study

### National market

- 4.50 As discussed further in chapter 8, national characteristics relating to the PH market due to the interactions between PH and PMI providers can be identified, as both PMI and PH providers set out in their submissions to the OFT in this market study.
- 4.51 PH providers have commented that competition takes place at the national level for inclusion on PMI providers' networks of recognised PH facilities at which their policyholders can be treated.
- 4.52 PH and PMI providers both note that contracts between PH and PMI providers for the provision of PH to PMI funded patients are agreed at the national level, and prices are generally set at the national level for these patients. In line with previous OFT and CC merger decisions and consistent with the OFT's analysis of submissions received, this market study has, therefore, considered competition at the national level.

### Regional market

- 4.53 The OFT has received divergent submissions across PH and PMI providers regarding whether there are regional elements to competition in the PH market or not.
- 4.54 A few PH providers submitted that competition does not take place at the regional level. However, one smaller PH provider and a number of PMI providers have commented that regional elements to competition exist, and are significant. One PMI provider in particular has stated that some PH providers have a strong presence in particular regions and that, as some corporate PMI customers are regionally based, there are regional aspects to competition in relation to these customers.
- 4.55 The OFT, therefore considers that there may be some regional aspects to competition. However, the OFT has focused in this market study on national and local elements to competition.
- 4.56 One of the larger PMI providers responded to the consultation indicating that they felt competition should be assessed on a regional rather than national basis as the five main PH provider chains do not compete at a

national level. The PMI provider suggested that framing the analysis along a national dimension suggests incorrectly that the five main chains compete with each other across the whole UK – each with lower shares of this wider market – when in fact there are many regions where only one or two of the main chains are present and have high shares (giving insurers and patients little choice).

- 4.57 The OFT acknowledges that regional elements of competition may vary by area. This may be something the CC wishes to consider further. The OFT has considered a possible national element to competition as this is the level at which PH providers and PMI providers negotiate to determine the price of treatments and the PH facilities at which the PMI providers' policyholders can be treated, as discussed above. However, the OFT considers that competitive constraints may be predominately local as they arise from patients' need to access local hospitals and that the large PH providers do not overlap with one another in every local area. Therefore, the OFT acknowledges that national market shares may overstate the competitive constraint imposed by the large PH providers on one another. This is discussed further in Chapter 6.

### Local market

- 4.58 Competition takes place between different PH providers at a local level to attract patients to their facilities. As discussed above, levels of local competition may also impact on the national negotiations between the PH and PMI providers.
- 4.59 The OFT market definition report found that there were several techniques that have been used to define local PH markets. These range from long established techniques, such as isochrone analysis, critical loss analysis and the Elzinga-Hogarty test,<sup>96</sup> to more recent, advanced techniques based on merger simulation, such as competitor share and

<sup>96</sup> This test uses hospitals' patient flow data to gradually expand the geographic area around the focal hospital(s) until the inflows of patients from outside the area into local hospital(s) and the outflows of local patients to external hospitals both fall below an arbitrary 10–25 per cent threshold.

structural merger simulation approaches. The OFT market definition report can be found on the OFT website.<sup>97</sup>

- 4.60 The OFT market definition report finds that the advanced techniques are conceptually more compelling, at least initially, compared to the earlier techniques. This is because, unlike the earlier techniques, the advanced techniques have been developed to account for the specific characteristics of the PH market, such as the heterogeneity of patients and PH facilities and the lack of sensitivity to prices of some patients (PMI funded patients especially). However, the OFT market definition report notes that these advanced techniques are only rarely likely to be viable and cost efficient for practical use by competition authorities in the UK because they require particular detailed patient level data that is often unavailable in the UK, and because the techniques are resource intensive.
- 4.61 The OFT market definition report notes that, if applying the more established, earlier techniques, an isochrone type measure is likely to be more appropriate than critical loss analysis or the use of the Elzinga-Hogarty test for defining PH markets. This is because both critical loss analysis and the Elzinga-Hogarty test rely on the assumption that PH patients are price sensitive, which is not an accurate assumption, especially for PMI funded patients.
- 4.62 In past OFT merger cases, the OFT has defined local PH markets using 30-minute drive time isochrones. The OFT considered, therefore, whether this previous geographic market definition at a local level adopted by the OFT in past merger cases continues to be appropriate.
- 4.63 The OFT market definition report found that isochrones based on drive times were more appropriate than fixed radius isochrones for defining local PH markets because fixed radius isochrones often lead to geographic markets being too widely defined in urban areas. Drive time isochrones take into account the local road networks and local speed

<sup>97</sup> Details regarding the different techniques for defining PH markets can be found in the OFT market definition report.

limits and so the markets are less likely to be too widely defined in urban areas, which typically have lower speed limits.<sup>98</sup>

- 4.64 The OFT received divergent submissions during the market study from PH and PMI providers regarding whether the 30-minute drive time isochrone is appropriate to assess local levels of competition. Some PMI providers, for example, considered that an approach to local geographic market definition based on such isochrones may be appropriate for initial assessments but may not be appropriate for all locations. In rural areas, for example, the appropriate drive time within which to assess competition may be longer.<sup>99</sup> In addition, the availability and range of transport links may also impact on the appropriate geographical definition. For London, drive times alone may not be appropriate for defining local geographic markets due to the high use of public transport and the high volume of commuters.
- 4.65 It has also been suggested by a PH provider that the relevant local geographic market may actually be determined by consultants' working patterns. This may be because GPs tend to refer to consultants based on patient feedback and the GP's knowledge of local consultants. In this context, the appropriate geographic scope of competition may be determined in part by the consultant's willingness to travel to different PH facilities.
- 4.66 The relevance of the role of consultants in assessing the relevant geographic market definition is also supported by the OFT GP survey. The survey found that GPs believed that one of the most important factors that influenced patients when they made their choice of PH facility or consultant was the reputation of the consultant.<sup>100</sup> Also most consultants (96 per cent from the OFT consultant survey) undertake a mixture of private and NHS work and so there may be time efficiencies

<sup>98</sup> OFT market definition report.

<sup>99</sup> One PMI provider has noted that they believe local markets are better defined using narrower drive time isochrones, and a case by case approach has also been suggested by one PMI provider. This would involve assessing each locality individually to determine which facilities compete at a local level.

<sup>100</sup> OFT GP survey, page 28.

for the consultant in conducting their private work near their main NHS facility.

- 4.67 The OFT market definition report found that physician/consultant -based isochrones have been used to define PH markets in a paper by Luft and Maerki.<sup>101</sup> The OFT notes that such a technique is not prevalent and has been challenged on the basis that even if consultants are only willing to travel a given distance to treat PH patients, the patients will have a choice of a number of consultant and facility pairings. However, as discussed above, GPs mainly refer patients to a named consultant and so the patient may be limited to the PH facilities to which the consultant they are referred to is willing to travel.
- 4.68 Taking these factors into account the OFT considers that the relevant geographic markets are likely to be local, as well as national, in nature and it is appropriate for the purposes of this market study, given the timescale, the range of different local and national markets analysed in the market study and the data available, to assess local competition based on 30-minute drive time isochrones. Local markets are considered further in chapter 6 of this market study report.
- 4.69 In terms of consultants, geographical markets are also likely to be local. As discussed above, the majority of consultants undertake a mixture of NHS and private work and, therefore, consultants will typically have practicing privileges at a PH facility that is local to their NHS facility. This is supported by the OFT consultant survey, which shows that 85 per cent of consultants who responded travel between zero and 30 minutes between their NHS and main PH facility.<sup>102</sup>

### Conclusion on geographic market

- 4.70 For the purposes of this market study, on the basis of the evidence submitted, the OFT market definition report, its review of previous OFT, CC and EU merger decisions and after considering the consultation responses, the OFT considers that there are likely to be both local and

<sup>101</sup> OFT market definition report.

<sup>102</sup> OFT consultant survey, page 48.

national relevant geographic markets, with potentially some regional aspects to competition.

## Conclusion on Market Definition

- 4.71 As in the consultation document, the OFT has not reached firm conclusions on the definition of the relevant product and geographic markets concerned, as the OFT does not consider this to be necessary for an examination of the features of the PH market for the purpose of considering whether to make a MIR, as described by the OFT's MIR guidance. The guidance states that firm conclusions on market definition are unnecessary if the effect on competition of some feature(s) is clear enough.<sup>103</sup>
- 4.72 In conclusion, the OFT considers that the relevant product market is likely to be the provision of privately funded healthcare services. These are provided to patients via private facilities/clinics including PPU's, through the services of consultants and medical and clinical professionals who work within these facilities. In line with previous OFT and EU merger cases, the OFT has not included the NHS as a whole in the product market
- 4.73 The OFT's view remains that there are likely to be both local and national geographical markets. For the purposes of this market study, it is considered appropriate to assess local markets using 30-minute drive time isochrones. The OFT has also briefly considered regional markets where appropriate in this study as there are potentially some regional aspects to competition.

<sup>103</sup> *Market Investigation References – Guidance about the making of references under Part 4 of the Enterprise Act* (March 2006).

[www.offt.gov.uk/shared\\_offt/business\\_leaflets/enterprise\\_act/oft511.pdf](http://www.offt.gov.uk/shared_offt/business_leaflets/enterprise_act/oft511.pdf)

## 5 INFORMATION ASYMMETRIES

### Introduction

- 5.1 Accessible, standardised and comparable information is vital for ensuring that consumers can exercise informed choice so that markets work well. Information asymmetries, where suppliers have better information about the quality and price of a product than consumers, can dampen competition between suppliers and result in poor outcomes for consumers in terms of price, quality, innovation and productivity.
- 5.2 Certain information asymmetries are inevitable in healthcare markets given that patients are unlikely to know more about their condition than a medical professional, nor able to navigate their choices effectively without expert advice. Clinical procedures are typically experience or credence services where quality may not be directly observable by the patient. This means that experienced specialist judgments are often part of evaluating options and making choices between consultants and PH facilities. Most patients therefore place central importance on their GPs' advice concerning different consultants and PH facilities for this reason.
- 5.3 Over the course of the consultation, the OFT received many submissions commenting on the information issues outlined within this chapter. Whilst the majority of these submissions acknowledged that information asymmetries existed in PH, some submissions questioned the OFT's views on the level and effects of such information asymmetry. Additionally, a few submissions argued that any current information issues could be addressed successfully without a reference to the CC.
- 5.4 The OFT has carefully considered representations which queried the consultation document's views on these issues, but, for the reasons given below, the OFT remains concerned that there is a current shortage of easily comparable information on the quality and price of different PH facilities and consultants available to GPs, patients and to PMI providers. This shortage may weaken the ability of these groups to drive efficiencies and to stimulate competition between different PH facilities and between consultants, and may give rise to a dampening of competition in the PH market overall.

5.5 This chapter examines the extent of information asymmetries in PH and their consequences in four main sections:

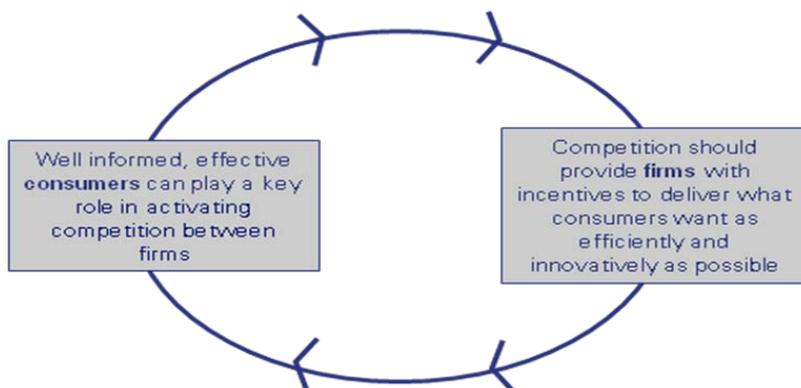
- the first section considers the importance of accessible, clear information for choice and competition in markets, and reviews how choices are made by patients in the PH market
- the second section examines the current levels of information on the quality and prices of PH facilities and assesses the harm that may arise from an existing lack of standardised, comparable information
- the third section looks at the same issues in relation to a lack of information regarding consultants
- the fourth and final section addresses an important consequence of information asymmetries: the impact on the ability of PMI providers to inform their policyholders' choices and decisions in seeking better quality treatments and on the PMI providers' methods for constraining prices. This section considers how information asymmetries may result in PMI providers adopting what appear to be a number of blunt and potentially distortive policies in order to limit consultants' costs.

## **Informed choice and competition**

5.6 The OFT believes that well functioning, competitive markets are characterised by active and informed consumers. As set out in Figure 5.1 below, active consumers exert pressure on firms to improve their product and service offerings. Informed consumer choice ensures that consumers are more likely to receive services that they need, and less likely to be inefficiently supplied services from which they do not benefit. This activates competition by rewarding those providers that deliver the best services that most suit consumers' needs.<sup>104</sup> Ultimately, empowered consumers and open competition drive innovation and productivity.

<sup>104</sup> For further information setting out the OFT's views on this dynamic, please see: Office of Fair Trading, *Empowering consumers of public services through choice-tools*, April 2011, OFT1321.

**Figure 5.1: 'The virtuous circle' - the role of firms and consumers in driving effective competition**



Source: The Office of Fair Trading

- 5.7 Well functioning markets do not require all consumers to be active and well informed. It is sufficient that some consumers exercise informed choice, or that some others exercise informed choice independently on the consumers' behalf. It is key that those consumers that are willing and able to exercise well informed choices have the information to do so.
- 5.8 In relation to healthcare, patients clearly represent a widely diverse population and may differ in the degree to which they value choice and require different types of information on which to base choices. In addition, and in the context of PH, patients can follow different pathways in accessing treatment<sup>105</sup> and self-pay patients are particularly likely to value choice in terms of price as well as quality. However, despite this diversity, recent research has indicated that patients in general value choice over their treatment.<sup>106</sup>

<sup>105</sup> OFT patient interviews, pages 18-22, sets out the different pathways that patients may follow in accessing PH.

<sup>106</sup> A recent report by the King's Fund has found that 75 per cent of patients surveyed thought that choice was either 'very important' or 'important'. (The King's Fund, *Patient Choice: How patients choose and how providers respond*, 2010, at executive summary (xiii)). Also, the 25<sup>th</sup> British Social Attitudes Survey (2009) reported that over 95 per cent of people think there should be at least some choice over which hospital a patient attends (as cited in OFT, *Choice and Competition in Public Services: Case Studies*, March 2010 OFT1214 at page 10).

- 5.9 In addition, GPs play a central role in how patient choices are made. The importance of the GP's role is confirmed by the OFT patient interviews which showed the large degree of trust and reliance that patients tended to place on their GP's opinion, with many patients seeking to delegate their choice of consultant to their GP.<sup>107</sup>

## Healthcare information asymmetries

- 5.10 Information asymmetries represent a significant feature of healthcare markets given that quality is often not directly observable to the patient. This is due to many clinical procedures either being experience goods, where a patient may find it difficult to make judgments about the utility or quality of a treatment prior to the procedure being carried out, or credence goods, where a patient cannot make any such judgment even after having the procedure (for example, on whether a diagnostic scan was necessary). In both these cases, the consultant will possess far greater experience and technical information in order to make these judgments.
- 5.11 There are established mechanisms for mitigating some of these information asymmetries in the PH market. As noted in chapter 3, the OFT fully recognises the valued (and valuable) role that GPs play in the patient journey as a trusted source of information and advice. Furthermore, regulators such as the Care Quality Commission (CQC) have a vital role in ensuring that common safety and performance standards are met by providers and in maintaining patient confidence in the healthcare system as a whole.<sup>108</sup>
- 5.12 However, the OFT is concerned that there remains a lack of accessible, standardised and comparable information readily available to patients, GPs and PMI providers to aid patients with the making of choices between providers (both in terms of PH facilities and consultants). The OFT's concerns remain that:

<sup>107</sup> OFT patient interviews, at page 28, also illustrates how some patients may be less interested in directly exercising choice.

<sup>108</sup> Following one submission received during the consultation, the OFT has sought further input from the CQC regarding whether it is currently able to remedy a number of issues identified in the OFT's consultation document. Further detail on this issue is found at paragraph 10.28.

- Current information regarding the quality of care offered by different PH facilities is too variable to compare easily.
- Current information regarding the quality of care offered by consultants is largely absent, making a patient's choice over a consultant dependent upon the GP's recommendation which is based on informal information and which may, itself, dampen demand side competition.
- The absence of information regarding the quality of care offered by consultants currently means that PMI funded patients cannot judge the value for money offered by agreeing to pay a 'top-up' fee<sup>109</sup> directly to the consultant. This is especially the case given that price may be used as a simple proxy for quality without any other supporting evidence.<sup>110</sup>
- There are potentially high search costs for self-pay patients in acquiring a breakdown of treatment costs at different PH facilities and a lack of the relevant information for judging value for money.
- In a significant number of instances, consultants may not be providing PMI funded patients with fee estimates prior to providing treatment and this leads to a lack of consultant fee visibility for both the PMI funded patient and the PMI provider. This increases the likelihood of PMI funded patients facing an unanticipated payment of a consultant's fee (a shortfall<sup>111</sup>) over the PMI provider's fee schedule<sup>112</sup> (or a 'customary level' normally reimbursed in full).

5.13 These main concerns, as detailed above, are supported by the OFT's own sources of survey evidence. Specifically, they indicate:

<sup>109</sup> For an explanation of a top up fee please see paragraph 3.32.

<sup>110</sup> Based on submissions made by PMI providers.

<sup>111</sup> Please also see paragraph 3.32.

<sup>112</sup> For a definition of fee schedule and how they operate, then please see paragraph 5.98.

- A lack of information left patients confused and hindered them from making an informed decision.<sup>113</sup> They did not have sufficient information to compare consultants and/or PH facilities.<sup>114</sup>
- Only a minority of GPs consider that 'all' or 'most' of their information needs regarding PH facilities were presently being met in regard to key PH facility performance variables, such as medical and clinical outcomes. Also, a significant number of GPs said that none of their information needs were met.<sup>115</sup>
- Only a minority of GPs consider that 'all' or 'most' of their information needs were presently being met in regard to key performance variables on consultants such as medical and clinical outcomes and prices. Again, a significant number of GPs also said that none of their information needs were met.<sup>116</sup>
- Only a minority of GPs felt that all their information needs were met in respect to the prices charged by PH facilities.<sup>117</sup>
- Consultants differ as to their practices in the provision of fee estimates to patients.<sup>118</sup>

5.14 The following sections consider how more comparable information on the price and quality of PH facilities and consultants could be made available to patients, GPs and PMI providers to help inform their choices and to stimulate competition between PH facilities and consultants in order to drive innovation and productivity as set out in paragraph 5.6 above.

<sup>113</sup> OFT patient interviews, page 47, paragraph 2.

<sup>114</sup> OFT patient interviews, page 47, paragraph 6.

<sup>115</sup> OFT GP survey, pages 30-31.

<sup>116</sup> OFT GP survey, pages 33-34.

<sup>117</sup> OFT GP survey, page 30.

<sup>118</sup> OFT consultant survey, pages 67-68.

## Current levels of information provision by PH facilities

### Quality information provided by PH facilities

- 5.15 PH providers choose to advertise the quality of their facilities to a range of different audiences including consultants, GPs, PMI providers and patients. The two types of information on the quality of their offerings which tend to feature heavily in PH providers' marketing materials are:
- patient satisfaction surveys
  - clinical performance indicators.<sup>119</sup>
- 5.16 However, across this body of information, the OFT has identified considerable variations in how this information is presented which may hinder a patient's ability to compare different PH facilities. In particular, some key variations include: differences in the types of clinical indicators and patient survey questions used, differences in whether the data relates to a single PH facility or the PH provider's entire PH facility network, and differences in patient satisfaction ratings and the various methodologies for formulating these ratings.<sup>120</sup>
- 5.17 Such variability may affect the ability of patients<sup>121</sup> to compare PH facilities and make an informed choice. The OFT understands that part of the reason for such variability in the format and display of comparable information on quality is the multiple systems used for recording private patient treatment episodes as managed by the different PH providers. Addressing this source of variability is the stated objective of the PH industry's Hellenic Project which is considered below.

<sup>119</sup> For instance, infection rates or unplanned returns to theatre.

<sup>120</sup> For instance, one PH provider combines 'good', 'very good', and 'excellent' for an overall percentage figure on patient satisfaction, whereas another PH provider uses 'very good' and 'excellent'.

<sup>121</sup> The OFT patient interviews also indicates that some patients (termed 'self-led') were more involved in seeking out information about PH facilities and thus more likely to come into contact with issues surrounding the variability of currently published data as already described.

- 5.18 It has been reported extensively that similar difficulties in displaying clinical indicators also exist for NHS facilities.<sup>122</sup> However, it appears that such difficulties are mitigated somewhat by the presence of the NHS Choices website<sup>123</sup> which has sought to provide a standardised display of key quality indicators across all NHS facilities.
- 5.19 All publicly funded NHS patient episodes undertaken by PH providers must be submitted to the Hospital Episode Statistics (HES) database which, along with other databases, provide the basis for much of the information displayed on NHS Choices.<sup>124</sup>
- 5.20 Whilst individual PH facilities may be listed on NHS Choices, the low volume of NHS funded episodes taking place in some PH facilities means that the data for certain key indicators is not sufficiently available in order to be displayed on the website.<sup>125</sup>
- 5.21 As NHS funded patient episodes represent only a subset of the work undertaken at most PH facilities, the low volume of HES records this produces (and their lack of representativeness for the entire number of treatment episodes taking place at a PH facility) means that a third party comparative information provider on healthcare options, such as Dr

<sup>122</sup> For examples of common difficulties in display of clinical indicators, see: The King's Fund, *How do quality accounts measure up? Findings from the first year, 2011*.

<sup>123</sup> See [www.nhs.uk/Pages/HomePage.aspx](http://www.nhs.uk/Pages/HomePage.aspx)

<sup>124</sup> All NHS Facilities in England contribute to the HES database and, by virtue of their contracts with the NHS, so will PH providers. Each HES record represents a single episode of care and can contain more than 50 pieces of information ranging from information about the patient (age, gender), clinical diagnosis and treatments, and administrative data such as dates of admission, discharge and, since 1998, a consultant code identifying the treating/supervising consultant. The HES database provides the basis for several information fields on the NHS Choices website such as: unplanned readmissions to hospital, adjusted mortality ratios, and volume data on number of operations/type undertaken.

<sup>21</sup> These fields often show the words 'insufficient data' or 'not held for...' and are attributable to low volumes of NHS funded patients.

Foster, has in the past been unable to provide comparable report cards<sup>126</sup> for PH facilities akin to those produced for NHS facilities.<sup>127</sup>

5.22 Overall, whilst PH facilities treating NHS patients will contribute to the HES database, this does not appear to result in a comprehensive, clear means by which PH facilities can be readily compared to each other or to NHS facilities in a standardised format.

5.23 Submissions to the consultation received by the OFT from some PH providers have sought to argue that, in its consultation document the OFT had:

- underestimated the degree of quality information that PH providers make publicly available on their PH facilities and its usefulness
- overestimated the degree of information that is hosted on the NHS Choices website and its usefulness.

5.24 As noted in the consultation document, the OFT acknowledges that PH providers publish a great deal of information on the quality and performance of their PH facilities. Such efforts correspond to PH providers' clear incentive to differentiate their healthcare offering – on the basis of quality of care – from their competitors. However, the OFT still believes that such information, as currently available, could be further improved in terms of enabling patients and GPs to compare facilities.

5.25 The OFT acknowledges that the NHS Choices website is not a panacea for the difficulties in comparing clinical performance amongst NHS Trusts, and that the level of information provided on these facilities' performance may differ on the basis of treatment type. However, the

<sup>126</sup> As seen at: [www.drfoosterhealth.co.uk/quality-reports](http://www.drfoosterhealth.co.uk/quality-reports) Dr Foster produces report cards for every NHS hospital based on a traffic light system display and risk adjusted indicators measuring performance across a number of clinical activities.

<sup>127</sup> Recently, Dr Foster has been able to produce comparable measures for some procedures (notably knee and hip replacements) undertaken at PH facilities in respect to NHS patient episodes only, and not for PH patient episodes. Furthermore, in its 2010/11 Hospital Guide, Dr Foster conducted an analysis of patient feedback comments including those on private facilities (however, these may also be largely dominated by NHS patient episodes given the sources for these comments).

OFT does believe that the standardised display and metrics used on the NHS Choices website provide an important basic level of comparability located at a single point of access which, at the present time, is still lacking within the PH sector.

## The Hellenic Project

- 5.26 The Hellenic Project is a PH provider-led initiative to develop a uniform system to record all privately funded treatment episodes in a manner which mirrors the HES database used by the NHS. Aside from its stated aim to improve benchmarking and quality improvement across the PH provider community, during the course of the market study the OFT was informed that a further ambition of the project is to provide, via published data, more comparable information on the quality of PH facilities for the benefit of patients.
- 5.27 The project started in 2009 and involves the main five PH providers. The OFT has been informed that a central challenge for the project has been collating the output from the various individual IT systems and databases of the different PH providers into a standardised format, and the OFT recognises that any such project will require a significant investment of time and resources.
- 5.28 In its consultation document, the OFT welcomed this initiative and its aim of providing access to more standardised, comparable information on the quality of PH facilities for patients. However, the OFT also had two broad concerns. These were:
- **Comparison with NHS:** As outlined in greater detail in Annexe B of the consultation document, during the market study the OFT heard stakeholder concerns over whether the output of the Hellenic Project, if successful, would allow effective comparison with NHS facilities for the benefit of all patients (regardless of funding source). Some stakeholders also questioned whether the degree of comparability across the quality information relating to PH facilities envisaged to be provided to patients by the Hellenic Project's output was sufficient. Overall, the OFT shared these concerns.
  - **Need for mandated PH involvement and a committed deadline:** In order to ensure effective comparison between PH facilities, the OFT took the view that the project would need to deliver accessible,

standardised and comparable data for all PH facilities. To achieve this, the OFT considered that some PH providers may need to be mandated to participate fully in the project and make the requisite investments in IT systems necessary for the realisation of the Hellenic Project's objectives.

5.29 Consultation submissions from most of the larger PH providers involved in the development of the Hellenic Project, have commented that:

- future outputs from the project (clinical indicators and patient satisfaction results) will be comparable with NHS information (and, in any case, currently published quality information is more comparable than the OFT had outlined in its consultation document)
- future anticipated outputs from the Hellenic Project negate the need for an MIR to the CC (and that an MIR could slow down the progress of this industry-led development due to the level of uncertainty that may be created during the period of investigation).

5.30 As part of its submission, one large PH provider supplied the OFT with a list of clinical indicators and other data envisaged to be published by the Hellenic Project which, for some indicators, seemed to go beyond the level of detail typically found on the NHS Choices website.<sup>128</sup> This submission also emphasised how these proposed indicators and other data would be comparable to NHS information.

5.31 Although submissions from the five larger PH providers did detail their desire to publish data relating to quality across PH facilities in a more comparable form, none of these submissions addressed the issue of whether it would be sufficient for participation to remain voluntary or whether delivery of the anticipated outputs from the Hellenic Project could only be assured if such participation was in fact mandated in order to prevent a PH provider from either not joining or opting out at a later date.

5.32 The OFT notes that information asymmetry in PH is a long-running issue, and believes that progress made in the public sector seems not to have

<sup>128</sup> In particular, this related to the degree at which a clinical indicator might be available by a specific procedure rather than at an aggregate level for a hospital's range of procedures – such as readmission rates or number of transfers to another hospital for instance.

been matched by the private healthcare industry. During the market study, several stakeholder expressed concerns about the lack of progress made by the Hellenic Project at the time, and so the OFT welcomes the recent efforts of PH providers to refocus on the project.<sup>129</sup> The OFT believes that this renewed focus on achieving the Hellenic Project's intended outputs need not be affected by any investigation by the CC and notes that, during the consultation, one larger PH provider closely connected to the Hellenic Project's development supported the OFT's provisional decision to make an MIR.

- 5.33 Several consultation submissions from PH providers to the OFT emphasised that PMI providers must also be more involved in supporting the development, and dissemination, of accessible, comparable PH facility quality information, as well as acting as a better conduit for conveying PH facility quality information to their policyholders. Furthermore, the OFT notes that one PH provider submission stated that whilst there should be 'ready comparison to NHS quality information', this should be combined with a more fundamental approach which seeks to ask patients, GPs and PMI providers what information they require about PH facilities in order to drive choice.
- 5.34 Overall, having considered consultation submissions from all the larger PH providers involved in the project, the OFT's concerns in relation to the availability, or anticipated availability, of standardised, comparable PH facility quality information are not fully addressed by the current proposals of the Hellenic Project and the OFT considers a MIR remains an appropriate way to further address this issue. In particular, the OFT remains concerned that – whilst moving in the right direction – the self-regulatory Hellenic Project may not be robust enough to ensure the provision of appropriately standardised, comparable information from all PH facilities, and believes that allowing the CC to examine this area will allow a holistic look at the information needs of patients and their advisors when considering private treatment.

<sup>129</sup> See article: *Private Hospitals Alliance on hold as focus shifts to Hellenic Project* as published on the HealthInvestor website (posted 09/02/2012)

## Price information for PH facilities

- 5.35 For PMI funded patients, the cost of a PH facility's inpatient charges will be covered by the PMI provider provided that the PH facility is listed on the PMI providers' network (see chapter 8). During the course of the OFT's market study, the OFT received no evidence detailing situations where a PMI funded patient had unexpectedly been required to bear the cost of the PH facility's inpatient hospital charges by its PMI provider. A PMI funded patient is therefore unlikely to be price sensitive in his/her choice of PH facility.
- 5.36 By contrast, self-pay patients are likely to be more price sensitive and they could in principle play a role in driving price competition between PH facilities. For self-pay patients, the evidence received in this market study suggests that information relating to the pricing of different treatments at a PH facility tends to be upfront and transparent,<sup>130</sup> and that many PH providers offer 'package prices' for various treatments where the consultant's fee is combined with the PH facility's entire hospital charges.
- 5.37 However, the OFT continues to have some concerns about the ability of self-pay patients to compare one quoted PH facility price for a treatment with another PH facility price in order to evaluate whether a quoted price represents value for money. In particular, search costs incurred by self-pay patients in obtaining individual quotes for treatment may be increased given that:
- there is some variation as to what may be included in a package price and this may vary by treatment and by PH facility
  - unless they have a private GP, self-pay patients may not be able to rely on their GPs for advice concerning the cost of specific clinical procedures at a particular facility as this information is not likely to be known by the GP<sup>131</sup>

<sup>130</sup> OFT patient interviews, at page 38.

<sup>131</sup> As with other information types, only a minority of GPs in the OFT GP survey felt that all their information needs were met in respect to prices (page 31).

- a number of self-pay patients, as reported in the OFT patient interviews, did not feel they had enough information about PH costs in order to negotiate on price with a PH facility in an informed way.<sup>132</sup>

- 5.38 Following consideration of consultation responses by PH providers on the subject of self-pay PH, the OFT accepts that the bespoke nature of PH treatment may be an inherent complexity which may make it more difficult to compare quoted prices for prospective treatment. Furthermore, the tailoring of price dependent on the patient's individual circumstances may weaken the level of reliance that can be placed upon indicative prices for treatments published in PH providers' own marketing materials and website.
- 5.39 Whilst accepting these issues in self-pay price setting, the OFT remains concerned about the level of cost awareness that self-pay patients may possess prior to accepting treatment. These concerns stem from individual consumer complaints received by the OFT over the course of its market study, details from the OFT patient interviews which noted that patients did not have enough information to negotiate in an informed way and the information needs of GPs as highlighted in the OFT GP survey.

### Specific harm arising out of PH facility information asymmetries

- 5.40 The OFT remains concerned that the ability of a patient to make an informed choice between PH facilities (as opposed to consultants – see below) appears to be impaired by a lack of accessible, standardised and comparable information on the quality of PH facilities. This makes it difficult for patients to evaluate – either independently or with the assistance of their GP or PMI provider – any choice they may have in relation to different PH facilities other than on the basis of geographical location and/or waiting times.<sup>133</sup>

<sup>132</sup> OFT patient interviews, at page 39.

<sup>133</sup> OFT patient interviews, page 48, conclusions 6 and 9.

- 5.41 Whilst the location of a PH facility currently appears to be an important factor bearing upon a patient's choice, there is evidence to suggest that patients may rate other factors such as the quality of care or infection rates more highly and would therefore be willing to travel further afield if such accessible, standardised and comparable information were available.<sup>134</sup>
- 5.42 Whilst GPs consider that individual information sources for PH facilities are useful,<sup>135</sup> significant numbers of GPs do not consider that the majority, or even any, of their information needs were presently being met as to key PH facility performance indicators across a range of factors, such as medical and clinical outcomes, prices and waiting times.<sup>136</sup>
- 5.43 At the present moment, the PH market compares unfavourably with the NHS in terms of the ability for patients to compare the quality of different facilities.<sup>137</sup> Whilst not discounting the significant challenges involved in developing and providing access to such standardised comparable quality information, the OFT considers that more opportunity should be afforded to patients (regardless of funding type) to compare PH facilities across both sectors in order to enhance their ability to make informed choices regarding treatment.
- 5.44 As set out in paragraph 5.37 above, it is also possible that self-pay patients may be at a disadvantage in being able to evaluate whether a price for a particular PH treatment represents value for money. This may be especially the case given that self-pay patients do not tend to

<sup>134</sup> For instance, within the context of a hypothetical choice experiment, the King's Fund found that 45 per cent of patients surveyed would choose a non-local provider on the basis of differences between hospital characteristics. (See King's Fund, *Patient Choice: How patients choose and how providers respond*, 2010, at page 152). Furthermore, the National Patient Choice Survey found that the location of the hospital ranked below cleanliness/low levels of infection and quality of care in factors considered important for patients when choosing a hospital [in total location came sixth out of the 10 factors identified] (See DH *Report on the National Patient Choice Survey*, March 2009, at page 8).

<sup>135</sup> OFT GP survey, page 30, (Figure 2.30).

<sup>136</sup> OFT GP survey, page 30.

<sup>137</sup> See above at paragraphs 5.12 and 5.13.

negotiate the prices of their medical treatment and tend to accept the price quoted to them.<sup>138</sup>

- 5.45 The OFT considers that the current absence of access to, standardised, comparable information on the quality and self-pay prices of PH facilities, weakens the ability of patients, GPs and PMI providers to drive efficiencies and stimulate competition between rival PH facilities and this may give rise to a dampening of competition between PH providers.
- 5.46 During the consultation, the OFT heard from one PH Provider who asserted that the OFT had not established a dampening of competition between PH providers stemming from a lack of standardised comparable information. In particular, the submission stated that:
- there was a lack of evidence of patients or PMI providers paying prices above competitive rates or receiving a sub-standard quality of service
  - the OFT had not addressed the role of GPs and consultants in driving competition between PH providers.
- 5.47 On the first issue, the OFT recognises that it has not been able to present detailed pricing data due to limitations in the data received during the market study, but believes this is a consideration which merits a more detailed, second stage investigation. However, on the second point, the OFT considers that it has assessed the competitive dynamics at play in private healthcare when examining consultant and GP decision-making via the two commissioned surveys, in addition to extensive stakeholder evidence.

## **Current levels of information provision by consultants**

### **Quality information for consultants**

- 5.48 There appears to be a shortage of accessible, standardised, comparable information relating to the clinical performance of consultants for the benefit of patients, GPs and PMI providers.

<sup>138</sup> OFT consultant survey, at page 68, found that 43 per cent of consultants reported that their self-pay patients 'never' attempted to negotiate the level of their fees.

- 5.49 Currently, the information accessible to patients on consultants offering PH is largely restricted to a directory of consultant names, their specialities and the locations where these consultants may practice.<sup>139</sup> Standardised, comparable information relating to a consultant's clinical performance is not generally available either to patients, GPs<sup>140</sup> or PMI providers,<sup>141</sup> and neither is such information available for consultants also working in the NHS.<sup>142</sup> Additionally, in relation to information on the locations where consultants practice, the OFT's consultant survey indicated that consultants themselves tend not to give their patients a choice between PH facilities for treatment.<sup>143</sup>
- 5.50 The OFT is aware that certain surgical specialities have been making headway in relation to the provision of data which can provide a basis for comparison between consultants' clinical performance. A key example of this, as presently available to patients, is in cardiothoracic surgery where risk adjusted survival rates for each surgeon are available, although this information is not currently hosted on the CQC's website as it had been previously.<sup>144</sup>

<sup>139</sup> OFT patient interviews, at page 47, conclusion 2.

<sup>140</sup> As shown in: *The King's Fund: An Anatomy of GP Referrals, 2007*, where GPs were described as having: 'a sort of 'mental' filing cabinet of informal information or soft intelligence about local consultants.' (page 20), see pages 19-22 in particular.

<sup>141</sup> OFT consultant survey, at page 50 (3.3.4), shows that just 14 per cent of consultants share information about clinical outcomes or complications arising from their private practice with PMI providers.

<sup>142</sup> The OFT notes that, as recently outlined in *Liberating the NHS: Greater Choice and Control* Government response: Choice of named consultant-led team (DH Oct 2011), the NHS is set to allow patients the ability to choose a consultant-led team from April 2012 where clinically appropriate. DH's consultation on this proposal found that there was a need for good quality information to support choice, and NHS providers will have to publish greater information about such consultant-led teams (such as their clinical specialities). See [www.dh.gov.uk/prod\\_consum\\_dh/groups/dh\\_digitalassets/documents/digitalasset/dh\\_131005.pdf](http://www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131005.pdf)

<sup>143</sup> OFT consultant survey, at page 53, shows that under half of consultants (48 per cent) said that they never offered patients a choice between their main PH facility and another PH facility.

<sup>144</sup> This is a product of the Society for Cardiothoracic Surgery in Great Britain and Ireland's development and collection of benchmarked outcome data. The OFT understands that the CQC is in ongoing discussions regarding the future hosting of the site.

- 5.51 The OFT considers that there would be considerable benefit in extending similar types of standardised performance measures to other clinical specialities where possible in order to address information asymmetries.
- 5.52 The OFT acknowledges the views of some medical associations which have outlined significant methodological difficulties in defining meaningful and objective clinical performance measures for some specialities, whilst also warning how such measures may create perverse incentives.<sup>145</sup>
- 5.53 In its consultation document, the OFT noted that some clinical specialisms – such as in bariatric surgery<sup>146</sup> – may be more amenable than others in developing clinical performance measures. The OFT then went on to state its view that even limited ‘clinical performance information’ such as ‘basic volume data’ may be beneficial to patients seeking to choose between consultants.
- 5.54 Following consultation submissions on this section of the consultation document, the OFT accepts that volume data is not a ‘clinical indicator’ in the same vein as other outcome or process measures. The OFT’s comments in regard to the use of basic volume data sought to highlight its potential value in lieu of clinical indicators (this contrast having been raised in the OFT roundtables – see Annexe B of the consultation document). The use of volume data is further considered below at 5.91.
- 5.55 The OFT considers that while a short term investment may be necessary to establish robust indicators of clinical performance, such an investment is very likely to be rewarded by significant improvements in choice, competition and standards over the longer term.<sup>147</sup> This is because performance information helps to inform patient choice, which drives

<sup>145</sup> As discussed at the OFT roundtables, see Annexe B of the consultation document.

<sup>146</sup> In regard to the development of the National Bariatric Surgery Registry (NBSR).

<sup>147</sup> The OFT notes proposed changes to consultant revalidation and appraisals process (being taken forward by the GMC) which may in the future mean the collection of more data on consultant performance by the Royal Colleges / Surgical Societies. As numerous stakeholders emphasised to the OFT both during and after the market study, this highlights the need for these institutions to lead the way in developing clinical performance measures at consultant level, and the OFT hopes that the forthcoming CC investigation will provide another platform for these developments to be supported.

competition between consultants. It also provides a benchmark by which consultants can gauge their own performance. This can ultimately raise performance standards across the market.<sup>148</sup>

## Consultant fee visibility

- 5.56 Most PMI providers publish fee schedules which establish the maximum level at which they will reimburse the consultant for a specific procedure. If a consultant's fee is unexpectedly over that fee schedule, it is the patient who is liable for this difference, and this may be paid directly to the consultant by the patient.
- 5.57 PMI funded patients tend not to be price sensitive.<sup>149</sup> The effect of PMI cover appears to rule out any discussion of the consultant's fee for the procedure despite the fact that the PMI funded patient is made liable for any difference which may arise.<sup>150</sup>
- 5.58 Although professional guidance to consultants working in private practice – in addition to the CQC standards<sup>151</sup> applying to the PH facilities they operate in – emphasises the need for upfront transparency on the issue of fees wherever possible,<sup>152</sup> the use of fee estimates by consultants and the timing for when these estimates may be given to a

<sup>148</sup> See The Society for Cardiothoracic Surgery in Great Britain & Ireland, *Maintaining patients' trust: modern medical professionalism* (2011), where a new model focusing on robust data on clinical outcomes is identified as the reason for a 50 per cent reduction in risk adjusted mortality in the UK, page 13.

<sup>149</sup> See paragraph 4.1

<sup>150</sup> OFT patient interviews, at page 48, conclusion 8.

<sup>151</sup> CQC is a regulator of quality and safety under the Health and Social Care Act 2008, it has confirmed that Regulation 19 of the CQC Regulations relating to fees provides for a 'statement' which must be in writing and as far as possible, is made available before the services are provided. However, CQC cannot mandate that the information is always provided before the service is received, although it suggests it should only be exceptional where it is not.

<sup>152</sup> For instance, see point 11 of FIPO's Patient Information Leaflet available at: [www.fipo.org/resources/rar-leaf.pdf](http://www.fipo.org/resources/rar-leaf.pdf) and GMC Good Medical Practice Guide available at: [www.gmc-uk.org/static/documents/content/GMP\\_0910.pdf](http://www.gmc-uk.org/static/documents/content/GMP_0910.pdf)

patient vary greatly between consultants.<sup>153</sup> For instance, the OFT consultant survey found that less than half of consultants provided a fee estimate at the first consultation.<sup>154</sup>

- 5.59 Some PMI funded patients may not be aware of the possibility of incurring a shortfall, assuming that the total fee will automatically be covered by their PMI provider. Others may not seek to pre-authorise their treatment, or even if they do, may not be in possession of an estimate of the consultant's fee (and the CCSD code<sup>155</sup> for the procedure) in order to check with the PMI provider prior to the procedure whether the entire cost will be covered. The OFT has raised this issue with the FSA and has made a recommendation to PMI providers in this regard.<sup>156</sup>
- 5.60 Levels of shortfalling and the need for top-up fees can differ sharply across different clinical specialities and between different procedures. Evidence submitted to the OFT in the market study suggests that anaesthetics constitutes a clinical speciality with a high rate of shortfalling and payment of top-up fees as compared to other

<sup>153</sup> During the consultation, the OFT received one submission which questioned the OFT's evidence in regard to the provision of consultant fee estimates, noting that the survey showed that around seven out of 10 consultants do provide fee estimates at some point. However, the OFT believes that the first consultation is the critical stage where a patient can still opt between consultants prior to switching costs becoming too onerous. As a result, the OFT believes that its views on the incidence of fee estimates at this early stage remains highly relevant.

<sup>154</sup> OFT Consultant Survey, page 128, provides the following breakdown: 'at the first consultation (43 per cent), 'once expected treatment process is agreed' (28 per cent), 'at a later stage' (six per cent), 'when treatment is complete' (one per cent), 'do not provide estimates before the final fee' (13 per cent). See also FIPO's own survey of its members (available at: [www.fipo.org/docs/axa-ppp/survey-detail-may-2010.htm](http://www.fipo.org/docs/axa-ppp/survey-detail-may-2010.htm)) where 30.7 per cent of consultants did not give fee estimates.

<sup>155</sup> The Clinical Classification and Schedule Development Group (CCSD) - a group of representatives from the five main PMI providers - maintains a schedule of treatment codes covering clinical procedures undertaken in PH. Further information can be found at [www.ccsd.org.uk/Home](http://www.ccsd.org.uk/Home)

<sup>156</sup> See Chapter 9. The FSA is in contact with the Association of British Insurers and PMI providers so that the incidence of shortfalls will be made clearer to consumers in their policy literature and also at time when a consumer seeks authorisation to make a claim under his/her policy.

specialities.<sup>157</sup> This may be due to patients having limited opportunities to choose between different anaesthetists. PH patients' contact with anaesthetists can often be limited and sometimes restricted to a brief meeting on the day of the treatment.<sup>158</sup> The ability of patients to negotiate lower fees may be reduced through the concentration of anaesthetists as members of anaesthetist groups in certain local markets. This is considered further in chapter 7.

- 5.61 Finally, in relation to fees for a first consultation charged by consultants, the OFT GP survey found that most GPs rarely or never knew a consultant's first consultation fee and, when prompted, a number of GPs requested better information in regard to these fees.<sup>159</sup> The OFT notes that some consultants do publish their fees for first consultations online, although – like the giving of fee estimates – this practice also seems to differ between consultants.<sup>160</sup>

### Specific harm arising out of consultant information asymmetries

- 5.62 In general, the OFT's research suggests that PH patients, GPs and PMI providers would value greater information on the clinical performance and quality of care offered by consultants.

<sup>157</sup> Based on submissions from a number of PMI providers.

<sup>158</sup> The OFT notes that out of the (albeit small) number of patients interviewed, only two patients raised the subject of their anaesthetists, at page 32. It is also the case that a surgeon, at the time of booking the procedure, may not know the identity of the specific consultant. For instance, see FIPO's template consultant booking letter (available at: [www.fipo.org/resources/index.htm](http://www.fipo.org/resources/index.htm)) which allows room for this possibility via its wording.

<sup>159</sup> OFT GP survey, pages 34-35.

<sup>160</sup> During the consultation, the OFT received one submission which questioned the robustness of the OFT's evidence in regard to consultant price transparency for first consultation fees. Whilst the OFT may not have posed this question to a substantial body of private patients (this relates to difficulties in obtaining a sufficient sample of private patients), the OFT consultant survey did ask 401 consultants whether they made fee information available to patients prior to the first appointment. This question showed that 49 per cent of consultants did not make any information on their fees available to patients prior to the first appointment (OFT consultant survey page 67). This result supports the OFT's provisional decision that a large degree of variability seems to exist in regard to consultant's practices in making fees known to private patients.

- 5.63 For patients, the lack of access to standardised and comparable information further strengthens their natural reliance on the GP's expert opinion in regard to consultant choice,<sup>161</sup> and patients therefore tend to choose a consultant who is suggested by their GP.<sup>162</sup>
- 5.64 Following consultation submissions, the OFT wishes to clarify that – as stated elsewhere in the report – patients will quite naturally rely on their GP's expert opinion due to the complex nature of medical treatment and their trust in the GP's duty to consider their best interests. This significant degree of reliance is separate from and not created in reaction to the absence of standardised comparable information. However, the OFT does believe that the current lack of standardised comparable information impairs some patients' ability to have a more meaningful discussion with their GP when a choice of consultant is offered and thus weakens demand-led competition in the PH market.
- 5.65 As the consultation document stated, GPs tend to refer patients to named consultants rather than providing an 'open referral' to a PH facility.<sup>163</sup> The main factor GPs tend to consider when making a referral is the consultant's reputation.<sup>164</sup>
- 5.66 For GPs, as was the case with information for PH facilities, individual sources of information for consultants tended to provide only 'some' useful (as opposed to 'significant' amounts of information), and most GPs indicated that only 'some' or even 'none' of their information needs were presently being met as regards key consultant performance measures.<sup>165</sup>
- 5.67 GPs use their knowledge from relationships with specific consultants, feedback from patients, information from marketing materials provided

<sup>161</sup> The OFT patient interviews, page 47, conclusions 2, 6 and 9. See pages 41- 46, theme 6.

<sup>162</sup> OFT GP survey, pages 24-25.

<sup>163</sup> Evidence submitted to the OFT by PMI providers typically identified around nine out of 10 GP referrals being made to named consultants rather than an 'open' referral.

<sup>164</sup> OFT GP survey, page 22.

<sup>165</sup> OFT GP survey, page 35.

by PH facilities and informal social contacts with health professionals to help them advise patients as to treatment options.<sup>166</sup> Given the lack of access to standardised, comparable information on the clinical performance of consultants, information obtained via word of mouth and past patient experience<sup>167</sup> may be particularly influential and relied upon by GPs when recommending a consultant.<sup>168</sup>

- 5.68 Although this 'soft' intelligence may provide information to aid choices locally and is to be valued, it will not assist patients who, if provided with relevant information, may want to be treated by consultants other than those with whom the GP is familiar. These factors may be especially the case where a GP (such as a locum) has little connection with the local area and is therefore not privy to the types of soft, local information typically utilised.
- 5.69 Over-reliance on soft intelligence or informal views can also raise the risk of entrenched referral patterns or biases which dampen demand-side competition in PH. It may also inhibit efforts by the GP to explain to the patient the basis for their recommendation of a particular consultant or to elaborate to a patient a meaningful choice of consultants.<sup>169</sup> Such a reliance on soft intelligence may also not result in a comprehensive

<sup>166</sup> This dynamic is found in *The King's Fund: An Anatomy of GP Referrals, 2007*, and can also be detected via consultants' own preference for informal networking with doctors when seeking to build their private practice (OFT consultant survey, pages 45-6).

<sup>167</sup> OFT patient interviews, page 27, where a patient had reported that: '...the preferred consultant (from a list of three) was someone the GP had referred a lot of patients to and who had received positive feedback from them.'

<sup>168</sup> OFT GP survey, pages 32 and 55-6, shows that 72 per cent of GPs used informal social contacts with health professionals as a source of information about privately practising consultants (the second most common source after information sent by PH facilities), and that the most common method for consultants to increase their private work was via informal networking with doctors (66 per cent), whilst over a quarter also mentioned visiting/contacting GPs.

<sup>169</sup> OFT patient interviews, page 27, reported that: 'Where GPs did make recommendations, clear reasoning was not always provided and participants did not always know why a particular consultant or hospital had been recommended. Where lack of information caused the most confusion was when the GP provided a number of choices, but gave no information about what differentiated one consultant from the other. In such a situation, participants did not see a benefit in being provided a choice'.

information platform for the making of a fully considered, informed choice on the part of the patient.

5.70 During the consultation, one submission from a PH provider asserted that the OFT had inaccurately described the information available to GPs as set out above. The OFT does not accept this characterisation of its consultation document, but by way of clarification, would emphasise that:

- The OFT's GP survey found that significant proportions of GPs felt that their information needs were unmet.
- The information used by GPs to support referrals – such as past patient feedback and firsthand experience of the outcomes of previous referrals – are of course valuable for supporting referrals to consultants and should be (and are being) harnessed by the GP in guiding patients.

5.71 Overall, the OFT believes that better access to standardised comparable information on consultant performance would be of use to GPs in assisting their patients when considering treatment options in private healthcare. Furthermore, greater standardised and comparable information would support the GP in advising a PMI funded patient whose choice of consultant may be limited via restrictions in their PMI policy. The OFT believes that a greater supply of comparable information, far from displacing the GP's role, would enhance it whilst supporting informed choice.<sup>170</sup>

5.72 Furthermore, the OFT considers that the exercise of an informed choice in this context is especially important given recent research evidence to suggest that clinical performance may vary substantially between different consultants/consultant teams.<sup>171</sup>

<sup>170</sup> This is especially the case given that forty-one per cent of GPs do not see it as their role to simply mandate their patients towards a particular consultant, see OFT GP survey, page 19 (2.2.5).

<sup>171</sup> A recent study indicating such variability is: 'Variation in reoperation after colorectal surgery in England as an indicator of surgical performance: retrospective analysis of Hospital Episode Statistics', Burns et al, BMJ 2011; 343:d4836.

- 5.73 During the market study, the OFT heard from a number of stakeholders outlining how an increased emphasis on the provision of comparable clinical information in some specialities, such as cardiothoracic surgery, has enabled a step change in quality by providing a measure by which consultants can benchmark their performance against others and a means by which patients can make informed choices and thereby drive competition between consultants. The OFT considers that the current lack of access to standardised, comparable information on the quality or clinical performance of consultants weakens the ability of patients and GPs to stimulate competition between consultants and drive performance standards and quality overall.
- 5.74 The OFT believes that variability in the use of fee estimates by consultants may also harm PMI funded patients by preventing them from obtaining a prior warning of a potential shortfall from their PMI provider and the option to find an alternative consultant who charges within PMI fee schedules.
- 5.75 Additionally, in relation to the possibility that a patient might be willing to agree a top-up payment with a consultant prior to treatment, without greater information regarding the quality of care being offered by the consultant (either in that specific treatment episode or historically), a PMI funded patient has little ability to establish whether a consultant's higher fee represents higher quality of care and is thus a price worth paying over and above the limits permitted under the patient's PMI fee schedule (further issues relating to PMI fee schedules are considered in the following section).<sup>172</sup>

### **The CQC's role in addressing information asymmetries**

- 5.76 During the consultation, one PH provider asserted that the CQC – via its powers and remit under the Health and Social Care Act 2008 (HSCA) – is well placed to address concerns about information asymmetries as identified by the OFT and that this negates the need for an MIR to the CC. However, for the reasons set out in detail at Chapter 10 (paragraph

<sup>172</sup> As the first-phase investigator, the OFT has not been able to examine whether any specific PMI provider's fee schedule is effectively 'underinsuring' for the treatment cost it compensates for, and would recommend that this issue is afforded further examination going forward.

10.28), the OFT does not accept this view and believes that an MIR to the CC represents the appropriate next step.

## The information role of PMI providers

### PMI provider advice to patients

- 5.77 In addition to GPs, PMI providers can play a role in advising insured patients of their treatment options. Some PMI funded patients expect their PMI provider to provide advice on their choice of PH provider and consultant.<sup>173</sup> The OFT's GP survey also shows that 16 per cent of GPs identified a patient's PMI provider as the most important influence on the choice of PH facility and/or consultant,<sup>174</sup> and around 20 per cent believed that the choice of facility or consultant was suggested by the PMI provider.<sup>175</sup>
- 5.78 PMI providers' submissions to the OFT have also indicated that affordability is a key issue for customers choosing to purchase PMI, and PMI providers therefore seek effective controls over prices charged by consultants to limit PMI premium rises. In the absence of price sensitivity on the part of PMI funded patients,<sup>176</sup> PMI providers have a significant role in constraining the costs of PH, in order to limit rises in premiums to maintain affordability.
- 5.79 Patients may rely on PMI providers to advise on fees charged by consultants at the pre-authorisation stage,<sup>177</sup> especially as this is an aspect of treatment that many GPs do not consider that they have a role in (and patients would not expect them to advise on this<sup>178</sup>). If contacted

<sup>173</sup> OFT patient interviews, page 42.

<sup>174</sup> OFT GP survey, page 27.

<sup>175</sup> OFT GP survey, page 25.

<sup>176</sup> OFT patient interviews, pages 37-38.

<sup>177</sup> Prior to obtaining treatment, PMI funded patients may contact their PMI provider to seek preauthorisation of the choice of PH facility and consultant in order to check that they are both recognised by the PMI provider. Preauthorisation is not however mandatory.

<sup>178</sup> OFT patient interviews, page 38, where no patient interviewed discussed costs with the GP.

by the patient in advance, PMI providers may try to limit the patient's (and their own) exposure to additional fees by providing the following information:

- whether the prospective consultant has historically charged above the PMI provider's fee schedule, or if the fee estimate the patient has been given is above the PMI provider's fee schedule (such as Bupa's 'Benefit Maxima')<sup>179</sup>
- if the consultant fee rate is 'capped' by the PMI provider.

5.80 One PH provider's consultation submission asserted that the OFT had not sufficiently considered the potential conflict of interest between the wishes of a PMI funded patient to receive high quality treatment and the incentives of the PMI provider in paying for that treatment. The PH provider stated that the incentives of a PMI funded patient and PMI provider were not as closely aligned as the OFT had assumed in its consultation document, and that a PMI provider's incentive to constrain costs could harm the quality of healthcare provision for patients.

5.81 In response, the OFT considers that whilst there may be potential for a conflict in incentives between PMI providers and policyholders (as perhaps evidenced elsewhere in this report), the OFT believes that this would be bounded by the PMI provider's desire not to weaken the quality of its offering in comparison with competitors. Overall, the OFT believes that this broad argument cannot be concluded as part of a first-phase enquiry, and as such could be better examined by the CC.

### PMI provider attempts to control consultants' costs

5.82 As described above, PMI providers play a role in assisting patients to make value for money choices of consultants. However the OFT believes that, in the absence of quality information on consultants and a lack of consultant fee visibility, PMI providers may adopt what appear to be a number of blunt and potentially distortive policies in order to control costs.

<sup>179</sup> Given Bupa's share of the market for PMI, its published benefit maxima is often considered to be the industry standard in terms of reimbursement rates. See OFT consultant survey, pages 69-70 which illustrates how many consultants base their fees on Bupa's benefit maxima.

5.83 The OFT has received a great deal of correspondence from consultants and their professional, medical associations in this market study expressing concerns about the ways in which PMI providers seek to control costs. These submissions tend to focus on the low level of the reimbursement rates contained in PMI fee schedules and other methods used to contain costs as considered below.

### Managed care

5.84 Submissions and evidence from consultants and medical associations have described a practice whereby the PMI provider may become more actively involved in their policyholders' care. This extra involvement may range from influencing the choice of consultant by way of requiring 'open referrals' from GPs, to the provision of a detailed clinical pathway that the consultant should adhere to when providing treatment.

5.85 The benefits to the PMI provider of exerting more control over the patient's treatment options (and critically, the identity of the treating consultant) is that it can control costs to a greater degree, perhaps guaranteeing that medical fees fall within the level at which it normally reimburses in full.<sup>180</sup>

5.86 However, the OFT has also received submissions from consultants, medical associations and PH providers which allege that the practice of managed care by PMI providers has resulted in inappropriate referrals to consultants who are not sufficiently experienced or specialised to treat the PMI funded patient's particular condition. These submissions have included specific examples where re-referrals to another consultant were subsequently seen. PMI providers have told the OFT that such instances are rare.

5.87 The OFT has not looked into this issue fully given that it would be wholly inappropriate to make clinical judgments as to how appropriate (or not) the original referrals may have been. However, it has raised this issue with the FSA and the Financial Ombudsman Service (the Ombudsman) who have confirmed that consumers should make complaints regarding inappropriate referrals in the first instance to the

<sup>180</sup> The OFT understands that some PMI providers may operate more varied schemes such as co-payment.

PMI provider, and then, should they remain dissatisfied, to the Ombudsman.<sup>181</sup>

- 5.88 During the consultation, some PH provider submissions criticised the OFT for its decision not to investigate these alleged incidences of inappropriate referrals in greater detail and also submitted that the OFT had not sufficiently distinguished 'managed care' from other patient pathways where the PMI provider provides advice and alternative providers for the patient to consider.
- 5.89 In regard to distinguishing managed care, the OFT did describe managed care as being characterised by 'extra involvement' (5.84 above) including, in particular, the choice of the consultant. However, the OFT would like to clarify that 'managed care' would refer to a situation where the PMI provider actively restricts the list of available consultants for their policyholders (rather than offering alternatives).
- 5.90 In regard to the OFT's approach to allegations of inappropriate referrals, the OFT stands by this approach and notes that, during the consultation, one significant medical association expressed its support for the OFT's way of dealing of this issue. The OFT does not accept that it would have been in any way appropriate – based on its expertise and level of resources – to have embarked upon a detailed examination of complaints concerning allegedly inappropriate referrals based on specialist clinical judgments that would have differed in each instance.
- 5.91 The OFT remains of the view that at least some of these adverse outcomes may be associated with the lack of consultant quality information currently available to private patients (or, alternatively, more basic volume information on number and type of procedures

<sup>181</sup> The Ombudsman has produced an example of a relevant complaint (and others in relation to PMI) and its resolution in Ombudsman News issue 77 (May/June 2009) - see [www.financial-ombudsman.org.uk/publications/ombudsman-news/77/77-medical-insurance.html](http://www.financial-ombudsman.org.uk/publications/ombudsman-news/77/77-medical-insurance.html). The FSA will monitor this issue and take action if required.

undertaken). The OFT believes that the likelihood of such inappropriate referrals could be reduced if patients could see which types of procedures a consultant had carried out over a certain time frame.

## Capping of consultants

- 5.92 Many of the complaints received by the OFT from consultants and medical associations relate to some PMI providers' practice of capping consultants' fees. Evidence submitted to the OFT indicates two main sorts of 'capped' consultants:
- **Capping of new consultants** whereby new consultants, as a condition of being granted recognition by a PMI provider, must set their fees within the PMI fee schedules and give assurances that they will not pursue the PMI funded patient directly for any shortfall.
  - **Capping of consultants at customary levels** whereby consultants who regularly submit fees over a specific amount are capped at an average level although they are still free to charge PMI funded patients directly for the shortfall incurred between their fee and this average level.
- 5.93 Complaints received by the OFT from consultants have stressed that the PMI providers' practice of capping and not allowing consultants to seek top-up payments is unfair, arbitrary, and risks forcing consultants out of the market or reducing the supply of consultants available to treat privately funded patients.
- 5.94 The OFT understands the complaints of new consultants, however, the OFT also believes that the lack of any other method by which to distinguish the entire population of consultants on the basis of quality means that PMI providers have little alternative criteria on which to base their cost control measures.
- 5.95 This view also extends to more established consultants being capped at customary levels, where, without demonstrable information relating to clinical performance, PMI providers are constrained from entering into informed individual negotiations with these consultants in order resolve conflicts over regular shortfalls to patients.

- 5.96 In general, price or fee caps are capable of distorting supply in markets. Low price caps may result in an under supply as there may be insufficient incentives for consultants to enter the market. They may also result in an under provision of quality that some patients may prefer. On the other hand, high price caps can generate incentives for consultants to price at the cap level, particularly where prices may be a proxy for quality.
- 5.97 Overall, while price or fee caps are, in principle, capable of distorting supply in markets, the OFT has not seen evidence to suggest that the supply of consultants has been affected.<sup>182</sup>

### Fee schedules

- 5.98 Most PMI providers publish fee schedules which establish the maximum level at which they will reimburse the consultant for a specific procedure. Consultants who wish to charge more than this schedule will have to charge top-up fees directly to the patient.
- 5.99 Previous considerations by the MMC in 1994<sup>183</sup> and the OFT in 1999<sup>184</sup> on how PMI providers reimburse consultants found that Bupa's benefit maxima represented downward pressure on consultant fees in a market where consultants are relatively unconstrained in the prices they set.<sup>185</sup>

<sup>182</sup> Conversely, 58 per cent of currently practicing consultants surveyed have spare capacity. The OFT consultant survey, Figure 3.49 page 48. Additionally, evidence from PMI providers has not shown a sharp downturn in the number of new consultants seeking PMI recognition (albeit at a 'capped' rate).

<sup>183</sup> Competition Commission, *Private Medical Services: A report on agreements and practices relating to charges for the supply of private medical services by NHS consultants* (Cm 2452) (1994) available at: [www.competition-commission.org.uk/rep\\_pub/reports/1994/348privmedical.htm#summary](http://www.competition-commission.org.uk/rep_pub/reports/1994/348privmedical.htm#summary)

<sup>184</sup> A press release for this study can be accessed at: [www.of.gov.uk/shared\\_of/market-studies/40\\_99.pdf](http://www.of.gov.uk/shared_of/market-studies/40_99.pdf)

<sup>185</sup> '...we find that the setting of the BUPA benefit maxima is a legitimate step by BUPA in carrying out its functions as an insurer. Insurers must be able to inform policyholders of the benefits they will receive if they claim for events that are covered by their policies. BUPA and the other insurers are the principal counterweight to the consultants, given the weak position of patients. The BUPA benefit maxima have had a restraining effect on consultants' charges.', (paragraph 1.11 of the 1994 report cited at footnote 183).

- 5.100 Top-up fees are also a more flexible tool for controlling PMI costs as, in principle, they allow those patients who wish to pay a consultant fee above the PMI fee schedule, in return for higher quality treatment to do so. However, the OFT considers that the lack of access to standardised, comparable information about quality of care provided by consultants makes it difficult for PMI providers to control costs in ways that might be more flexible such as top-up fees or more graduated consultant fee structures. Overall, the OFT believes that it would be in the greater interests of all parties (PH providers, consultants, PMI providers and patients) to seek to develop better comparable information so that less blunt and potentially distortive measures for cost control could be developed whilst supporting the ability of patients to make informed choices on their treatments outcomes.
- 5.101 Ultimately, current information asymmetries in relation to quality and price of consultants may be preventing the development of more sophisticated methods for controlling costs and judging trade-offs between cost and quality. For PMI providers, this results in the use of blunt tools for cost control such as capping, and for PMI funded patients, this results in an inability to evaluate whether a potential top-up payment offers value for money and is worth paying.<sup>186</sup>

### **Conclusion: information asymmetries**

- 5.102 The OFT considers that there is a shortage of accessible, standardised and comparable information provided to patients and their advisors in relation to the quality of PH facilities and of consultants. There also appear to be difficulties for PMI funded patients in assessing the risk of shortfall from particular consultants, whereby a consultant's fees exceed the benefit maxima that the patient's PMI provider will reimburse resulting in the potential for an additional payment by the patient. In addition, for self-pay patients, there are difficulties in easily comparing the prices charged by different PH facilities.
- 5.103 In general, the OFT considers that this shortage of accessible, standardised and comparable information weakens the ability of patients and GPs to drive efficiencies and stimulate enhanced competition between rival PH facilities and between consultants, and may give rise

<sup>186</sup> As described at paragraph 5.75.

to a dampening of competition in the market overall. The lack of access to information on quality and price for consultants appears to produce a situation where both the patient and PMI provider cannot differentiate between consultant performance and fees in order to judge whether they represent value for money. This may be preventing the development of more flexible, less distortive methods for PMI providers to control consultant costs, whereby patients can choose between consultants on the basis of their respective fees and quality and pay a top-up fee to the consultant, above the maximum provided by their insurance cover, if a patient judges it to be worthwhile.

5.104 Finally, the OFT notes that information asymmetries are a factor across a number of other features examined in this report, including the limits on the ability of PMI providers to exercise buyer power which is examined in chapter 6. The lack of access to comparable quality information on PH facilities may also facilitate a competitive dynamic whereby competition between PH providers is based less on the quality of services provided to patients and, since a consultant often effectively seems to choose at which PH facility the patient is treated, more on attracting consultants to their PH facilities through the use of a variety of contractual and non-contractual incentives. This may increase the cost of PH without necessarily driving improvements in the quality of services provided to patients. The development of consultant incentives is examined in chapter 8.

## 6 CONCENTRATION IN PRIVATE HEALTHCARE PROVISION

### Introduction

- 6.1 This chapter examines concentration in the PH market. Market concentration is concerned with the 'number and size distribution of firms in a particular market. It is generally accepted that, other things being equal, the larger the market share of a firm, the greater its market power is likely to be, particularly if its high market share has persisted over a period of time and is relatively stable'.<sup>187</sup>
- 6.2 In line with the likely relevant geographic market,<sup>188</sup> the chapter begins with an assessment of the concentration of PH providers at the national level. The following section then examines concentration at the local level. This chapter also considers the concentration of purchasers of PH and in particular the significance of the interaction between PMI and PH providers.
- 6.3 Having carefully considered responses to the consultation, the OFT has amended its analysis of 'must have' PH facilities detailed in its consultation document, such that it does not state a definitive view in relation to specific 'must have' PH facilities in this report. Nevertheless, the OFT remains of the view that there is concentration of PH provision at the national level, and more importantly, high concentration of provision in some local markets. High levels of concentration in some local markets appear to restrict choice and competition in those markets and at a national level.
- 6.4 The OFT has also given careful consideration to consultation responses in relation to the potential buyer power of PMI providers. While the OFT acknowledges that the largest PMI provider may wield a degree of buyer power, as the recent development regarding the BUPA and GHG dispute - which is discussed further below - appears to illustrate, the OFT remains of the view that there may be limits to that buyer power, and

<sup>187</sup> *Market Investigation References - Guidance about the making of references under Part 4 of the Enterprise Act*, March 2006, page 26.

<sup>188</sup> As noted in the chapter 4 of this report, the OFT considers that the geographic market is likely to be both national and local in nature. There are also potentially some regional aspects to competition.

considers that it is unlikely to extend to other PMI providers to the same degree.

6.5 This chapter has three main sections. These are:

- concentration of PH providers at the national level
- concentration of PH providers at the local level
- scale and buyer concentration of PMI providers.

### Concentration of PH providers at the national level

6.6 As discussed above in chapter 4, it appears that there are national elements to competition across the PH market as this is the level at which negotiations between PH and PMI providers takes place, including the annual negotiations to agree the prices of treatments and the negotiations regarding at which of the PH provider's PH facilities the PMI provider's policyholders can be treated.

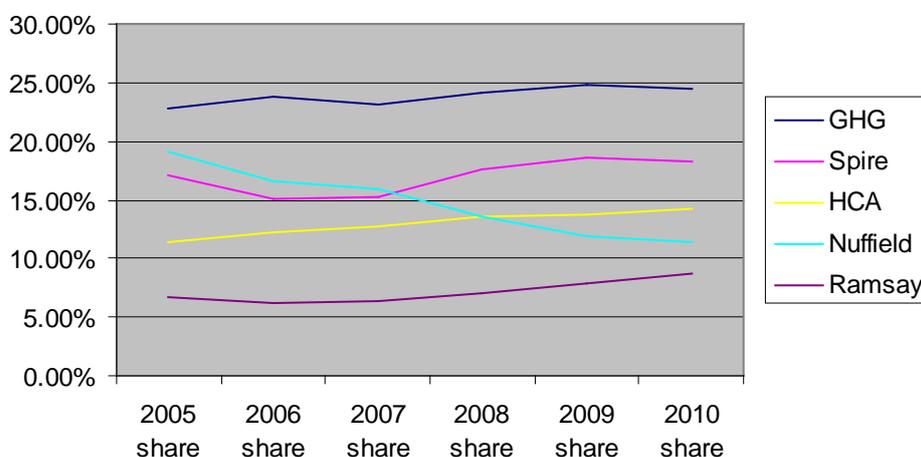
6.7 It can be seen from Table 6.1 below that the combined market share based on revenues of the five largest PH providers was approximately 77 per cent in 2010. As can be seen from Figure 6.1 below, the market shares of four of the five largest PH providers have remained relatively stable over the period 2005 to 2010.

**Table 6.1: National PH market shares by value, 2005 to 2010<sup>189</sup>**

Provider	2005 (per cent)	2006 (per cent)	2007 (per cent)	2008 (per cent)	2009 (per cent)	2010 (per cent)
GHG	22.9	23.8	23.2	24.2	24.8	24.4
Spire (previously Bupa)	17.1	15.2	15.2	17.5	18.6	18.2
HCA	11.4	12.3	12.8	13.6	13.8	14.3
Nuffield	19.1	16.6	15.9	13.6	12.0	11.4
Ramsay	6.8	6.2	6.4	7.1	7.9	8.8
<b>Top five providers</b>	<b>77.2</b>	<b>74.1</b>	<b>73.4</b>	<b>76.0</b>	<b>77.0</b>	<b>77.2</b>
London Clinic	2.5	2.8	2.8	3.0	3.2	3.3
Bupa Cromwell	2.3	2.4	2.2	2.1	2.0	2.0
Aspen	1.8	1.9	2.1	2.1	2.1	1.9

<sup>189</sup> Source: Data supplied by Laing & Buisson. The data excludes centrally procured ISTC activity and diagnostics for the NHS provided by specialist diagnostic providers. Notes: Classic Facilities was part of Bupa Facilities until its sale to L&G Ventures in July 2005. Spire bought out Bupa Facilities in August 2007 and acquired Classic Facilities in February 2008.

**Figure 6.1: Market shares for the five largest PH providers over the period from 2005 to 2010<sup>190</sup>**



6.8 Figure 6.1 above shows that GHG, Spire, HCA and Ramsay have all experienced growth over the period 2005 to 2010, although Spire experienced a temporary fall in its market share in 2006 and 2007 and GHG experienced a slight fall in 2007. Nuffield's market share has been declining during this period from 19 per cent in 2005 to 11 per cent in 2010. This could in part be due to a reduction in the number of PH facilities owned by Nuffield following the sale of nine of its PH facilities to GHG in 2008.

6.9 In the context of this market study, the OFT has calculated a Herfindahl-Hirschman Index (HHI)<sup>191</sup> for the national PH market using the market shares of the top eight providers outlined in Table 6.1 above. These values are set out in Table 6.2 below.

<sup>190</sup> Data supplied by Laing & Buisson. The data excludes centrally procured ISTC activity and diagnostics for the NHS provided by specialist diagnostic providers. Notes: Classic Facilities was part of Bupa Facilities until its sale to L&G Ventures in July 2005. Spire bought out Bupa Facilities in August 2007 and acquired Classic Facilities in February 2008.

<sup>191</sup> The HHI is a measure of the size of firms in relation to the industry. The index increases with concentration and ranges from zero (a very fragmented market) to 10,000 (a single supplier).

**Table 6.2: National PH market HHI values, 2005 to 2010<sup>192</sup>**

Year	HHI
2005	1,371
2006	1,280
2007	1,240
2008	1,330
2009	1,373
2010	1,360

- 6.10 In the OFT and CC Joint Publication, *Merger Assessment Guidelines*,<sup>193</sup> a market in which the HHI exceeds 1,000 is categorised as 'concentrated' and one in which it exceeds 2,000 is categorised as 'highly concentrated'.
- 6.11 The indices set out at Table 6.2 suggest that there was a decrease in national PH market concentration between 2005 and 2007, with a small increase thereafter until 2009. However, the national PH market would be categorised as 'concentrated' throughout the period.
- 6.12 As discussed in chapter 4, while there may be a national element to negotiations between the PH and PMI providers, some of the competitive constraints on PH providers (such as competing for PH patients and consultants) appear to predominately arise locally as PH patients want to be treated locally. These local constraints are likely to determine collectively national pricing during the negotiations between the PH and PMI providers. The OFT considers therefore that the national HHI will mask areas of high local or regional concentration as not all of the main PH provider groups are present in all areas. Therefore, the following section focuses on competition at the local level.

<sup>192</sup> Source: OFT calculations, based on data supplied by Laing & Buisson. The data excludes centrally procured ISTC activity and diagnostics for the NHS provided by specialist diagnostic providers.

<sup>193</sup> OFT and CC Joint Publication, *Merger Assessment Guidelines*, 2010. Available at: [www.of.gov.uk/shared\\_of/mergers/642749/OFT1254.pdf](http://www.of.gov.uk/shared_of/mergers/642749/OFT1254.pdf)

## Concentration of PH providers at the local level

- 6.13 Concentration of PH providers at the local level varies across the UK. Within the timetable of this market study, the OFT has not sought to assess the concentration of all potential individual local PH markets in the UK and indeed it would not be appropriate for a first phase enquiry. However, the OFT has looked at PH facilities described as solus and PH facilities described as 'must have' in seeking to understand the possible local market dynamics in the PH market.
- 6.14 The analysis below considers solus PH facilities, where there is no alternative PH facility within a 30-minute drive time before moving on to examine 'must have' PH facilities.<sup>194</sup>

### Solus facilities

- 6.15 PH facilities that have no competing fascia within a 30-minute drive time of the PH facility are described as solus.<sup>195</sup> The OFT has focused on areas of very high concentration by looking at solus PH facilities as (depending on geographic market definition) these could be considered local monopolies.
- 6.16 The definition above of a solus PH facility has been adopted in previous CC and OFT merger cases.<sup>196</sup> By definition, using HHI as the measure of

<sup>194</sup> As discussed in chapter 4 of this market study report, the use of drive time isochrones is considered to be an appropriate way of assessing local PH markets.

<sup>195</sup> British United Provident Association Limited and Community Facilities Group Plc: A report on the proposed merger; and British United Provident Association Limited, Salomon International LLC and Community Facilities Group Plc; and Salomon International LLC and Community Facilities Group Plc: A report on the existing mergers, December 2000. Available at: [www.competition-commission.org.uk/rep\\_pub/reports/2000/449bupa.htm#summary](http://www.competition-commission.org.uk/rep_pub/reports/2000/449bupa.htm#summary)

<sup>196</sup> These are: (i) Completed acquisition by General Healthcare Group of control of four Abbey hospitals and de facto control over Transform Holdings Limited previously part of the Covenant Healthcare Group, October 2010; (ii) Completed acquisition by Spire Healthcare Limited of Classic Hospitals Group Limited, July 2008; (iii) Completed acquisition by General Healthcare Group of assets of Nuffield Facilities, May 2008; and (iv) British United Provident Association Limited and Community Facilities Group Plc: A report on the proposed merger and British United Provident Association Limited, Salomon International LLC and Community Facilities Group Plc; and Salomon International LLC and Community Facilities Group Plc: A report on the existing mergers, December 2000.

concentration, an area with one PH facility would be considered extremely concentrated.

- 6.17 A few PMI providers have commented in submissions to the OFT that, while the use of 30-minute drive time isochrones is appropriate for the determination of a solus facility, such an approach, if used alone, would not identify all PH facilities that they consider have market power.
- 6.18 As noted in chapter 4, a 30-minute drive time isochrone is a useful proxy for defining local PH markets, and has advantages over other potentially more sophisticated techniques such as critical loss analysis.<sup>197</sup> It is possible that the application of such isochrones may under or over estimate the size of the local market that some PH facilities operate in. However, given the timescale of this market study, the range of local markets analysed, and the extensive data requirements necessary to undertake other analyses of local markets, the OFT considers that an isochrone analysis is appropriate to analyse local competition for the purposes of this market study.
- 6.19 In the consultation document, the OFT stated that there were 27 solus PH facilities in the UK owned by the five largest PH providers.<sup>198</sup>
- 6.20 One consultation response from a larger PH provider has stated that there are no solus facilities.<sup>199</sup> This is based on:
- the PH provider's view that the NHS as a whole provides a competitive constraint on PH providers
  - the assertion that consultants split their lists of patients between solus PH facilities and other PH facilities.<sup>200</sup>

<sup>197</sup> This is because critical loss analysis assumes that patients are price sensitive.

<sup>198</sup> The number of solus facilities, as identified by PH and PMI providers in their original submissions, owned by the five largest PH providers.

<sup>199</sup> While other responses received from PH and PMI providers that commented on solus PH facilities acknowledged that they did exist. Although a number of the larger PH providers stated that the presence of solus facilities does not provide PH providers with market power. This is discussed later in this chapter.

<sup>200</sup> The extent to which consultants split their lists of patients is examined in chapter 8.

- 6.21 Other PH providers have also commented that the NHS as a whole competes, albeit they have not stated that there are no solus hospitals as a result. As discussed in chapter 4, based on previous clear examples from the OFT and the EU in recent merger cases, the OFT does not consider it likely that NHS provision is in the relevant product market. However the OFT does note that the NHS has some impact on the demand for PH overall, particularly for self-pay patients as discussed in chapter 3.
- 6.22 In relation to consultants splitting their lists of patients at solus PH facilities, the OFT did not receive any evidence during the market study to show that this was prevalent in the market. As discussed in chapter 5, the OFT consultant survey showed that most consultants tend to treat their patients at only one PH facility and do not often give patients a choice of facility. To the extent that consultants may split their lists, this might be for a variety of reasons, including that different PH facilities provide different, complimentary facilities. It is not necessarily evidence that a solus PH facility faces a significant competitive constraint.
- 6.23 The OFT remains of the view that there are likely to be local PH markets that contain solus PH facilities and this is acknowledged by a number of the PH providers, including some of the larger PH providers.

#### 'Must have' PH facilities

- 6.24 In the consultation document, the OFT considered the concept of 'must have' PH facilities as several submissions received from PMI providers, one of the larger PH providers and a smaller PH provider during the course of the market study stated that there are PH facilities that are 'must have'. As set out further below, PMI providers described PH facilities that they felt had market power as a result of unique attributes they have in the local market, such as size or availability of equipment as 'must have' PH facilities on their networks.
- 6.25 The OFT, in the consultation document, set out these various views that a PH facility is 'must have' if one or more of the following circumstances arise:
- it is the only PH facility in a local area that provides a particular specialism or procedure, in which case the PMI provider may have no

choice but to recognise the PH facility if it is to offer policyholders sufficient access to the specialism or procedure in that local area

- other PH facilities in the local area do not have sufficient capacity and, as such, PH patients could not be diverted away from the PH facility
- a large proportion of the PMI provider's spend in a local area is with that PH facility.<sup>201</sup> This is because it is likely that the PMI provider would face significant redirection costs if they were to remove that particular PH facility from their PMI network. Redirecting policyholders in this way may, for example, have reputational risks for the PMI provider due to the inconvenience caused to its policyholders from being redirected to an alternative PH provider.

6.26 Responses from PMI and PH providers to the consultation regarding the concept/existence of 'must have' PH facilities have presented very different views. One of the larger PH providers, a number of the PMI providers and a smaller PH provider consider that 'must have' PH facilities exist as provisionally proposed by the OFT. In particular, the larger PH provider stated that the issues of national and local market concentration are exacerbated by the distribution of solus and 'must have' hospitals in each PH provider's portfolio. The smaller PH provider commented that excluding certain hospitals would lead to a customer proposition for PMI providers that would be unattractive and, therefore, they should be regarded as 'must have' facilities.

6.27 The OFT included the concept of 'must have' in the consultation document as the submissions received from the larger PMI providers suggested that there are PH facilities required by their policyholders which must, therefore, be listed on their networks.

6.28 In addition, one of the larger PH providers submitted that at least one of the larger PH providers has reached a level in terms of scale that makes it 'must have' for PMI networks. Another of the larger PH providers also stated in a meeting with the OFT that there are PH facilities that must be included on any PMI provider network.

<sup>201</sup> This spend relates to PMI providers reimbursing facilities for the cost of treatment on behalf of their policyholders, as mentioned in chapter 3.

6.29 However, responses to the consultation from a number of the larger PH providers have not supported the OFT's provisional view on 'must have' PH facilities for the following reasons:<sup>202</sup>

- A number of the larger PH providers have stated that the OFT's provisional view was based on submissions of PMI providers, rather than a full analysis of whether particular PH facilities are 'must have' or not.
- One of the larger PH providers stated that there is excess capacity in the PH market and so it is unclear how capacity constraints would prevent PMI providers from diverting patients from one PH facility to another.
- One of the larger PH providers has also stated that patients can be treated at a PH facility not included on a PMI provider's network and so PMI providers do not need to list PH facilities on their networks just because they are the only PH facility in a local area to provide a particular specialism.

6.30 While previous submissions, as discussed in paragraphs 6.24-6.28, point to an issue of 'must have' facilities in general, the OFT acknowledges that the initial analysis of 'must have' PH facilities has been based broadly on the submissions of different PMI providers. It also acknowledges that there may be different views on whether one PH facility is identified as 'must have' or not. This is because, due to their different circumstances,<sup>203</sup> a PH facility may be considered 'must have' by one PMI provider but not by another.

6.31 In relation to the submissions on capacity utilisation, the OFT received, as part of the market study, information relating to capacity utilisation

<sup>202</sup> A couple of PH providers have also commented that there may be pro-competitive reasons why a facility is considered 'must have'. For example a facility may be considered 'must have' because there has been investment by the PH provider to improve the quality/range of treatments offered and it has attracted the best consultants. This may be something the CC wishes to investigate further.

<sup>203</sup> These different circumstances may relate to, for example, the number of policyholders the PMI provider has in the particular area or the proportion of the PMI provider's spend in the local area that is with a particular PH facility, which will be vary according to the to the individual PMI provider.

from some, but not all, of the larger PH providers. The OFT understands that spare capacity is needed in order for consultants to treat their PH patients quickly. The information received indicated that the larger PH providers (that submitted data) did have excess capacity. However, the OFT also received capacity figures from a small PH provider which showed that the PH provider was operating close to capacity in terms of the availability of beds and theatre capacity. As part of the first phase enquiry, the OFT did not carry out a detailed analysis of the availability of spare capacity in all local PH facilities to ascertain whether the diversion of a PMI provider's policyholders to other local facilities is feasible. The OFT has, therefore, not formed a definitive view on this issue.

- 6.32 In conclusion, as noted above, the OFT has not conducted a full analysis, given this is a first phase enquiry, of the PMI providers' claims that some facilities are 'must have', and therefore forms no definitive view in this respect. It does however note the widespread concerns raised about 'must have' PH facilities in general. The OFT also considers it likely that certain PH facilities will be in a strong position in their local markets by virtue of having a large local market share. Thus, while the analysis above has focused principally on solus facilities, there are also likely to be a number of local markets with a high degree of concentration of PH facilities, such as those areas with two PH facilities within a 30-minute drive time. Further, one of the smaller PH providers submitted that the PH sector has consolidated since the late 1990s around local markets with one or two PH providers. This may, therefore, be an issue that is worth a detailed examination by the CC.

### The importance of local PH facilities and their impact on the PH market

- 6.33 The OFT patient interviews found that, in general, patients' primary concern when considering a choice of PH facility was to be treated locally.<sup>204</sup> This means that, in order to sell policies to customers in a local area, a PMI will most likely need to have access to PH facilities in that area. As a consequence, PMI providers recognise PH facilities all

<sup>204</sup> OFT patient interviews, page 47.

over the UK and create networks that provide nationwide coverage in order to provide policyholders access to PH facilities in their local area.

6.34 PMI providers also indicated to the OFT that policyholders, although wanting to be treated close to home, often also value a policy that offers nationwide coverage.<sup>205</sup> In addition, corporate clients<sup>206</sup> that have employees across the UK, in particular, are likely to value a PMI policy that offers nationwide coverage.

6.35 In order to offer policies in local markets, or to offer nationwide coverage, it would appear that PMI providers have to contract with most of the larger PH providers, as they own a number of solus PH facilities. As such, PMI providers appear to be dependent on the larger PH providers, as owners of solus PH facilities. This view is supported in the consultation responses from the PMI providers and a smaller PH provider.

6.36 A couple of the larger PH providers in their consultation responses disagree with the view that PMI providers require national coverage and suggest that:

- Patients only seek local cover and so would only be interested in their local PH facilities.
- One PH provider stated that the development of 'low cost' networks operated by Bupa and AXA PPP are examples of PMI providers not requiring nationwide coverage.

6.37 However, information provided during the course of the market study by PMI and PH providers suggests that there is a need for national coverage. One of the larger PH providers endorses this view in their internal documents submitted to the OFT during the market study which states that in order to sell PMI policies, PMI providers need to have access to a number of PH facilities across the country that can provide PH in the areas where their customers live and work. Also, even if

<sup>205</sup> This is also supported by one of the larger PH providers, which notes that in order to be able to sell PMI policies, PMI providers need to have access to a number of PH facilities across the country that can provide PH in the areas where their customers live and work.

<sup>206</sup> Six-nine per cent of PMI sales in 2010 were to corporate clients.

national coverage is not required for a particular PMI policy, PMI providers generally need to provide access to local PH facilities in order to provide PMI policies to local policyholders. If a PMI provider did not provide access to a solus PH facility, the PMI provider may find it difficult to sell PMI policies in that particular area. Therefore, the OFT remains of the view that PMI providers appear to need to recognise PH facilities across the UK in order to fulfil the local demands of policyholders.

- 6.38 In response to submissions regarding the 'low cost' networks, in the consultation document, the OFT noted that the 'low cost' networks do not include all of the PH providers or all of their PH facilities and as such, under a 'low cost' network, there may be local areas of the UK where PH patients may not have access to a local PH facility. PMI providers say that these new PMI policies are niche, lower priced policies aimed at individual policyholders, rather than corporate customers, who are willing to trade choice of PH facility for a lower premium. It is also likely that these products would predominantly be purchased by those who live in areas where a local PH facility is included on the 'low cost' network. Therefore, the 'low cost' networks are unlikely to be substitutes for the PMI networks that do offer nationwide coverage.
- 6.39 The consultation document stated that PMI providers have suggested that the ownership of solus PH facilities allows PH providers to leverage a degree of market power when negotiating in relation to recognition for all of their PH facilities;<sup>207</sup> this is considered further in chapter 8.

### Pricing and quality analysis

- 6.40 During this market study, the OFT requested data from PH and PMI providers with a view to undertaking a detailed assessment of whether the price charged by PH providers for treating the PMI providers' policyholders at specific PH facilities was impacted by the level of concentration in the relevant local area. However, although all stakeholders did provide data, this data did not provide a sufficiently robust basis on which to compare pricing at different PH facilities.

<sup>207</sup> The PMI providers and a couple of PH providers also point to 'must have' facilities as giving market power to the larger PH providers. However, see the OFT's assessment of these submissions at paragraphs 6.24-6.28.

- 6.41 A number of PH providers raised concerns about the proposed analysis during the market study. Some PH providers suggested that the OFT would need to control for quality and consultant preferences,<sup>208</sup> which would require the collection of additional data, and would need a similar dataset of all independent PH facilities that provide a competitive constraint on the PH facilities owned by the five largest PH providers. It was considered that collecting this additional data was not appropriate for a first phase enquiry and would place significant burdens on the PH and PMI providers, as well as OFT resources. The OFT has not undertaken, therefore, a related comparative analysis. This is a matter which the CC may wish to investigate further, if it is minded to do so.
- 6.42 The OFT also attempted to consider whether the service quality of specific PH facilities is impacted by levels of local market concentration. This is because where local market concentration is high, one might expect PH providers to be under less competitive pressure to increase their service quality. In the absence of published, comparable information on service quality, the OFT has assessed whether solus and other PH facilities described as 'must have' are more or less likely to be refurbished by way of a preliminary proxy for such an assessment.
- 6.43 Data relating to all refurbishment projects over £1 million undertaken over the period 2007-2010 was provided by some, but not all, of the larger PH providers. The data provided some limited evidence that solus PH facilities and other PH facilities described as 'must-have' were less likely than other PH facilities to have been refurbished between 2007 and 2010. As with the pricing comparison outlined at paragraph 6.4040 above, the underlying data is limited, and the OFT did not progress this analysis further.<sup>209</sup>

<sup>208</sup> PH providers noted that the price charged by the PH facility is impacted by the preferences of the consultant treating the patient. The PH providers note that it is the consultant that often chooses the drugs used, the prosthesis used and also the number of nights a patient would stay in hospital. These factors all impact on the price charged and as such the PH providers stated that the OFT would need to control for the consultant in any analysis.

<sup>209</sup> A couple of the larger PH providers have questioned why the OFT undertook this analysis. One PH provider commented that the hypothesis that quality would be lower at 'must have' PH facilities conflicts with the definition given by the PMI providers of what makes a PH facility 'must have' (the definition is set out at paragraph 6.25). The OFT has set out its reasons for

- 6.44 The OFT also noted in its consultation document that a number of PPUs have entered into partnering agreements with PH providers and this seems to be a growing trend. Currently the OFT is aware of 10 PPUs that are managed by PH providers.<sup>210</sup> There are also a number of PPU partnering agreements currently out to tender.
- 6.45 The OFT considers that the levels of concentration of some local markets may be affected by these partnering arrangements. Local market concentration may increase if a PH provider that is already present in the local market partners with the PPU that is part of the same local market. This has the potential to reduce competition in the local PH market because the partnering arrangement may lessen the competitive constraint on the relevant PH provider offered by the PPU prior to the partnering arrangement and reduce choice for PH patients and PMI providers. This concern is supported by a few of the PMI providers in their consultation responses.
- 6.46 If the PH provider partner is a new entrant in the market the impact of the arrangement on the local PH market is less clear. If the competitive constraint of the PPU on other local PH providers is increased as a result of the partnering arrangement,<sup>211</sup> one possible outcome is improved choice for PH patients and PMI providers. This is supported by a few of the PH providers in their consultation responses. However, this would need to be assessed on a case-by-case basis.
- 6.47 Therefore, the OFT considers that the concentration of some local markets may be impacted by these partnering arrangements. Whether

conducting this analysis at paragraph 6.42 but, having acknowledged that the limitations of the analysis, has not progressed it further within this first phase enquiry.

<sup>210</sup> The OFT is aware of the following from sources including Laing & Buisson, consultation responses and PH providers' websites; HCA Harley Street @ UCH, London; HCA Harley Street @ Queens, Romford; HCA Christies, Manchester; BMI Coombe Wing, Kingston; East Kent Medical Services manages Spencer Wing at Ashford and Margate; Ramsay Orwell Cardiothoracic PPU, Basildon; Nova Healthcare St James' Institute of Oncology PPU, Leeds; Spire Papworth Hospital Varrier Jones Ward, PPU Cambridge; Spire is developing the Royal Orthopaedic Hospital Trusts' PPU at Stanmore, and The Cambridge Heart Clinic, Cambridge.

<sup>211</sup> As discussed in chapter 4 of this report, the competitive constraint offered by PPUs on other PH providers varies.

PPU partnering arrangements should be notified to the OFT as possible mergers is discussed in chapter 9 of this market study report.

6.48 In conclusion, the OFT considers that patients prefer to be treated locally and, as such, PMI providers appear to have a strong incentive to provide access to policyholders' local PH facilities. To the extent that a local facility is solus, in order to best serve the needs of their policyholders in that local area, the PMI provider appears to be dependent on the PH provider that operates the local facility.

6.49 The OFT received a number of submissions from the larger PH providers which state that the PMI providers are not dependent on the PH providers as a result of their ownership of solus PH facilities. These PH providers claim that they do not enjoy market power and the PMI providers are in a strong position and exercise their buyer power during negotiations with the PH providers. The OFT considers the relationship between the PMI and PH providers below.

### **Scale and buyer concentration of PMI providers**

6.50 PMI funded patients account for approximately 59 per cent of revenue generated by PH providers, on average.<sup>212</sup> NHS patients account for approximately 25 per cent and self-pay patients<sup>213</sup> for the remainder.

6.51 The OFT has assessed the significance of the three main purchasers of PH in terms of their contribution to the economic viability of the PH providers. These purchasers of PH are:

- individual PMI providers
- the NHS<sup>214</sup>

<sup>212</sup> As discussed in chapter 3 of this report. Source: Laing & Buisson, *Laing's Healthcare Market Review 2011-2012*.

<sup>213</sup> Including self-pay patients from overseas.

<sup>214</sup> As noted in chapter 2, the OFT does not consider that publicly funded, privately provided services are within the scope of this market study, or within the scope of the relevant market. Nevertheless, the OFT does consider that it is relevant to assess the NHS as a source of revenue for PH providers since it impacts on the degree to which PH providers are dependent on PMI providers as a source of revenue.

- self-pay patients.

6.52 In the absence of available robust, reliable data for the market shares of the PMI providers based on purchases of PH, the OFT has used the national market shares of the PMI providers based on subscription income, as shown in Figure 3.3 in chapter 3, as a proxy to calculate the buyer side market shares of the PMI providers.

6.53 The OFT's calculations provide the following market shares for the purchasers of PH.

**Table 6.4: Buyer side shares of the value of PH purchases, 2010<sup>215</sup>**

Purchaser of PH	Market Shares %
Bupa	24
AXA PPP	14.7
Aviva	6.5
PruHealth	6.2
WPA	1.6
Other PMI providers	5.5
NHS	24.9
Self-pay	16.6

6.54 Table 6.4 shows there is a degree of concentration of purchasers of PH.<sup>216</sup> The larger PMI providers account for a large share of demand for PH, suggesting they may have a degree of buyer power.

6.55 In addition, the figures presented above in Table 6.4 may under-estimate the importance of the larger PMI providers to the viability of the PH providers. PH providers have stated that PMI funded patients are significantly more profitable compared to NHS patients and NHS patients

<sup>215</sup> Source: OFT analysis of data presented in Laing & Buisson, *Laing's Healthcare Market Review 2011-2012* Figure 2.4 and Table 3.14. Notes: 'self-pay' includes overseas patients that self-pay.

<sup>216</sup> It is important to note that self-pay patients purchase PH individually and not as a group so this portion of the market should not be viewed as a buying group. Similarly, NHS purchases of capacity from PH providers tend to be made by individual NHS trusts. PH providers treat publicly funded patients on the same terms as an NHS trust would treat a publicly funded patient and are typically paid the same price, which is determined according to the NHS tariff and set by DH.

are usually only treated to use spare capacity, such as theatres and beds, when otherwise these would be empty. One PH provider has stated that treating NHS patients is usually carried out to make a contribution to fixed costs already incurred (such as staff and theatre equipment) when otherwise there would be none. This is also supported by financial data, supplied by some of the PH providers and analysed by the OFT, which shows revenue earned from treating NHS patients often did not appear to cover all costs associated with treating NHS patients.<sup>217</sup>

- 6.56 This conclusion is supported by a few of larger PH providers in their consultation responses, who state that margins on NHS work are generally smaller than those achieved on PMI funded work and as such, given the high fixed cost nature of PH facilities, revenues from PMI providers are important to the viability of PH facilities. As set out below, the OFT considers that the importance of PMI providers' revenue to PH providers is likely to be greater than suggested by the shares presented in Table 6.4 and that the costs of being excluded from one of the larger PMI providers networks could be significant.
- 6.57 The majority of PH providers told the OFT during the course of the market study that they would find it very difficult to remain economically viable if they were not included on the facility networks of the major PMI providers. In particular, not being on the larger PMI providers' networks would undermine the viability of a PH facility.
- 6.58 This is further supported by Laing & Buisson, who report that 'not being included on Bupa and/or AXA PPP's networks could mean a significant shortfall in demand' for PH providers.<sup>218</sup> PH providers consider that this criticality provides the PMI providers with a strong starting negotiating position during the annual contract negotiations between PMI and PH providers.
- 6.59 Markets that have concentration on both the supply side and the demand side are often characterised by bargaining between suppliers

<sup>217</sup> In these cases, while a profit was made relative to treatment and building costs, only a contribution was made towards administrative and overhead costs.

<sup>218</sup> Laing & Buisson, *Laing's Healthcare Market Review 2010-2011*, pages 71-72.

and purchasers over the terms of supply (price, volume, duration of contract, degree of exclusivity). The relative bargaining strength of each negotiating party depends on a number of factors, for example the degree to which one party is dependent on the other to be economically viable, or whether there are credible outside options in terms of, for example, alternative suppliers or customers.

- 6.60 In the consultation document, the OFT considered that, while the larger PMI providers may be key trading partners for the PH providers, there may be limits on the ability of the PMI providers to exercise countervailing buyer power. This is supported by the PMI providers that responded to the consultation.
- 6.61 The OFT considered, in the consultation document that, because of the presence of solus and 'must have' PH facilities in a number of local areas, a PMI provider may not have credible alternative supply options in these areas. This may limit the ability of PMI providers to exercise countervailing buyer power in contract negotiations with PH providers, including the annual negotiations relating to the price of treatments.
- 6.62 Further, the OFT considered that it may be costly for PMI providers to remove PH facilities from their network. PMI providers state that removal of a PH facility could have reputational costs and lead to possible complaints to the Ombudsman as some policyholders may no longer consider their policy fit for purpose. PMI funded patients may also face costs associated with moving PH facility mid-treatment particularly if their consultant is unable to move with them or the inability to re-insure existing medical conditions with a PMI provider that does offer access to the local PH facility at which the patient has previously been treated. Therefore, PMI providers may find it difficult to switch to alternative PH providers in certain local areas.
- 6.63 The OFT received a number of submissions from the larger PH providers challenging the OFT's provisional view that the PMI providers are, to a degree, dependent on the PH providers due to their ownership of solus<sup>219</sup>

<sup>219</sup> One of the larger PH providers, in their consultation response, stated that the results of the OFT's GP survey that most GPs believed that their patients had a choice of at least two PH facilities and/or PH consultants was inconsistent with the OFT's finding that solus hospitals were widespread. However, the OFT notes that most of the PH providers themselves gave the OFT a list of their PH facilities that were considered solus. Also as part of the survey, GPs were

and 'must have' PH facilities and that they do in fact enjoy buyer power. The reasons for this are set out below:<sup>220</sup>

- One PH provider has noted that PMI providers have delisted solus PH facilities.
- A number of the larger PH providers point to the recent negotiations/dispute between GHG and Bupa, during which Bupa delisted a number of GHG's PH facilities for a number of weeks.
- A number of PH providers dispute the existence of 'must have' PH facilities (see paragraph 6.29 above).
- A few of the larger PH providers have also commented that the consultation document had overstated the reputational costs to PMI providers of removing PH facilities from their networks. One PH provider has claimed that PMI policies are renewed annually and the terms change from year to year and so there are no reputation costs to changing policyholders' policies.

6.64 In response to these points the OFT notes that the result of the dispute between BUPA and GHG mentioned above was that Bupa relisted most of GHG's facilities. One of the three facilities that continue to be delisted is suggested by a couple of PH providers to be solus. The OFT acknowledges that this example does show that Bupa, in this instance, was able to credibly threaten to delist a limited number of a GHG's PH facilities.<sup>221</sup> Delisting PH facilities does not appear to be widely used by

not specifically asked about full service hospitals and so it is unclear whether GP's are referring to single line service treatment centres, full service hospitals or other clinics when responding.

<sup>220</sup> One PH provider has also commented that the OFT did not use financial data provided to the OFT by PH providers, which could enable it to conduct a profitability analysis to determine if excess profits were being made by the PH providers. The OFT received data from some, but not all, PH providers contacted. The financial data received presented serious difficulties for comparing or aggregating data. Resolving these difficulties would have required an unreasonable amount of time to be invested by the PH providers and the OFT to ensure sufficiently robust results. This was not considered appropriate for a phase one enquiry and so an analysis was not published in the consultation document.

<sup>221</sup> This dispute involved the largest PMI provider, Bupa, and the largest PH provider, GHG. Press releases from both GHG and Bupa are available at:

PMI providers. A few of the PMI providers have described delisting as a 'nuclear' option.

- 6.65 However, the OFT's market study is concerned with how the market as a whole operates and it is not clear to the OFT that, and the OFT did not receive evidence to suggest that, delisting hospitals is a credible option for other, smaller, PMI providers. This is supported by one of the larger PH providers who acknowledges that the buyer power of the PMI providers varies significantly.
- 6.66 In relation to 'must have' PH facilities, as the OFT notes above, the OFT has, in the context of the first phase enquiry, not determined an objective methodology by which to assess PMI claims that some facilities are 'must have', and therefore does not state a definitive view in this respect. It does however note the widespread concerns raised about 'must have' PH facilities and considers it likely that certain PH facilities will be in a strong position in their local markets by virtue of having a large share of supply.
- 6.67 With regards to the reputational costs, the OFT considers that the removal of a PH facility from a PMI provider's network does appear to have some reputational costs for the PMI provider. As a result of the recent delisting of a number of GHG's PH facilities by Bupa, the OFT received complaints from individual consumers regarding their dissatisfaction at the removal of GHG's PH facilities. The OFT also received information from a few of the PMI providers who highlighted that as a result of the dispute with GHG, Bupa lost a number of corporate clients to other PMI providers.
- 6.68 The OFT also considers that some patients would be impacted negatively by the removal of their local hospital from their PMI provider's network. Patients who are mid-treatment or discover that they need follow up treatment may not wish to switch facility and potentially be treated by another consultant. Also, as discussed above, it is widely accepted that patients want to be treated close to home and for some policyholders their local PH facility may be a solus PH facility.

[www.bmihealthcare.co.uk/hospital/news?p\\_region\\_id=&p\\_news\\_id=2508](http://www.bmihealthcare.co.uk/hospital/news?p_region_id=&p_news_id=2508) and [www.bupa.co.uk/intermediaries/int-news/int-bupa-updates/bmi-hospitals-update](http://www.bupa.co.uk/intermediaries/int-news/int-bupa-updates/bmi-hospitals-update)

- 6.69 However, one of the larger PH providers also noted that PMI providers are able to sponsor entry,<sup>222</sup> which would give the PMI provider more choice in local markets. The PH provider points to two examples of one of the larger PMI providers sponsoring the entry of existing PH facilities into certain specialisms. The OFT acknowledges that sponsoring new entry would provide the PMI providers with alternative PH facilities in local markets. It is unclear, however, how prevalent this practice is and whether it is a credible option for smaller PMI providers.
- 6.70 The OFT considered, in the consultation document, that once a PH facility is included on its network, a PMI provider's buyer power may be further constrained by the limited ability of the PMI provider to direct patients' choices of PH facility, and thereby steer patient volumes between different facilities on the network. As noted in chapter 5, the patient's choice of PH facility is often determined by the patient's consultant, and in the absence of comparable information on the quality of different PH facilities it can be difficult for PMI providers to influence patient choices on the basis of value for money.
- 6.71 At the national level, it is also claimed by PMI providers that once a PMI provider has included a PH provider's portfolio of facilities on its network it would be difficult to remove that PH provider group from the PMI provider's network entirely. This is because the scale of the larger PH providers' portfolios of PH facilities appears to make it difficult to direct PMI funded patients away from all of the PH provider's facilities.
- 6.72 This may limit the PMI providers' buyer power as it appears to reinforce the need for PMI providers to continue to contract with all of the larger PH providers. This is supported by internal strategy documents submitted to the OFT by one of the larger PH providers, which indicates that increasing the number of facilities owned by the PH provider is important in improving their negotiating position with purchasers of PH, such as with PMI providers during the annual price negotiations and the negotiations regarding at which of the PH providers' PH facilities the PMI providers' policyholders can be treated.

<sup>222</sup> Sponsoring entry is a way of encouraging new entry into a market; typically this would involve sharing some of the start up costs or guaranteeing a minimum order value.

6.73 A number of the larger PH providers disagree that PMI providers have limited ability to direct patients and have suggested that PMI providers are able to direct patients through the following mechanisms:

- the introduction of 'open referrals' by a couple of the PMI providers
- a few PH providers have also stated that PMI providers are able to use network recognition, the pre-authorisation process and any subsequent authorisation processes to direct patients to alternative PH facilities.<sup>223</sup>

6.74 The OFT acknowledges, as considered in the consultation document, that the use of open referrals may reduce the difficulties facing PMI providers of directing patients, to some extent, and allow the PMI provider to gain some control over the choice of consultant and/or PH facility accessed. However, while that may be the case for those policies that do require policyholders to obtain an open referral, not all policies require open referral<sup>224</sup> and therefore if a patient is referred to a consultant that wishes to treat the patient in a recognised PH facility it is unclear how the PMI provider would direct the patient during the pre-authorisation process and any subsequent authorisation processes. This appears to be the case as it is still widely accepted in the market and shown by OFT's own surveys that patients place a lot of trust in their GP's recommendations on which consultant it is best for them to see and it is the consultant that chooses the PH facility at which to treat their patients.

6.75 Therefore, the OFT still considers that PMI providers are often not able to direct patients' choice of PH facility or consultant, although this difficulty may be reduced through the use of open referrals.

<sup>223</sup> One PH provider goes on to note that PMI providers will also be able to tell their policyholders where else the consultant that they have been referred to has practicing privileges. The OFT takes on board this point but it is unclear whether this is indeed possible. As discussed in this report, the OFT's consultant survey shows that most consultants tend to treat most of their patients in one PH facility.

<sup>224</sup> One PH provider has submitted that one of the larger PMI providers is trying to extend their open referral scheme and promote it to more of their policyholders. The PH provider notes that the PMI provider has the exclusive right to specify the consultant and the PH facility for the policyholder's treatment.

- 6.76 The OFT has also considered levels of regional concentration in relation to the exercise of buyer power by PMI providers, as some submissions from PMI and PH providers during the market study have commented that there are regions of the UK that have become increasingly concentrated in relation to the provision of PH.
- 6.77 The OFT considers that in areas where there are a number of solus PH facilities owned by a single PH provider and/or where there is high local concentration it may be particularly difficult for an individual PMI provider to switch to an alternative PH provider in that region. This may be particularly an issue for PMI providers' offerings to corporate clients which are based in particular regions.
- 6.78 The OFT, in the consultation document, stated that one such area that was raised by a number of PMI and PH providers is London. While the OFT has not specifically analysed London in detail, the OFT notes that it has received very mixed views regarding this area in terms of concentration and the power of PH providers that operate in this area.
- 6.79 The OFT is of the view, from considering all of the information received during the market study and in response to the consultation, that it would appear that the largest PMI providers may enjoy a degree of buyer power. However, it is not clear that smaller PMI providers are able to exercise buyer power in the same way.
- 6.80 The OFT also remains of the view that there may be limits on the ability of PMI providers to, in all situations, exercise buyer power due to the difficulties associated with directing patients away from PH facilities and the need for PMI providers to provide policyholders access to local PH facilities, some of which may be solus. In such a situation, where buyer power is limited, the relationship between the larger PH providers and the larger PMI providers is likely to be characterised as one of bargaining and interdependence - where each side is significantly dependent on the other for their position in the marketplace. This may also give rise to restrictions of competition to the extent that interdependence may result in relatively closed or locked-in relationships between buyers and sellers that can create a static market with low levels of entry or exit. Barriers to entry in PH are considered in chapter 8.

## **Conclusion: concentration in private healthcare provision**

- 6.81 PH provision appears to be concentrated at the national level. At the local level there appear to be examples of extreme concentration, such as areas where there is no alternative fascia PH facility within a 30-minute drive time of a particular PH facility (solus PH facilities). In addition, the OFT notes widespread concerns raised in submissions in response to the consultation document about the existence of 'must-have' facilities. While the OFT has not taken a definitive view on whether particular faculties are 'must have', it considers that there are likely to be a number of local markets with a high degree of concentration, such as those areas with only two PH facilities within a 30-minute drive time.
- 6.82 For the reasons set out above, including the desire of patients to be treated locally, there are reasonable grounds to suspect that these levels of concentration restrict competition in the provision of PH.
- 6.83 The purchasing of PH provider services is also concentrated at the national level. The size of the largest PMI providers appears to provide them with some buyer power in that PH providers are, to an extent, dependent on access to, and inclusion on, the networks of these larger PMI providers for the financial viability of their PH facilities. The emergence of 'low cost' PMI networks, open referrals and the recent delisting of hospitals by one of the largest PM providers support the existence of some buyer power at least among the largest PMI providers.
- 6.84 However, there may be limits on the PMI providers' ability to exercise such buyer power. Firstly, the degree of any such buyer power is likely to vary by size of the PMI provider in terms of its share of subscription income, and it is likely that not all PMI providers are large enough, on this basis, to exercise buyer power. Secondly, any buyer power may be constrained by the need for PMI providers to purchase PH in most local markets, including areas with solus PH facilities as described above, in order that their policyholders can be treated locally. Thirdly, PMI providers are likely to face at least some reputational costs if they carry out a threat to delist or exclude PH facilities from PMI networks. Further, beyond the exclusion of PH facilities from their networks, PMI providers have limited ability to direct patients to different PH facilities since in

most cases GPs rather than PMI providers recommend the consultants, and consultants often determine a patient's choice of PH facility.

6.85 The OFT notes that the development of partnership arrangements between the PPUs of NHS/Foundation Trusts and PH providers has the potential to either exacerbate or alleviate any concentration concerns in local PH markets. Local market concentration may increase if a PH provider that is already present in the local market partners with the PPU. This is because the partnering arrangement may lessen the competitive constraint on the relevant PH provider offered prior to the partnering arrangement and reduce choice for PH patients and PMI providers. On the other hand, a partnership arrangement between a PPU and a new PH provider in the local market has the potential to provide a platform for entry and thereby to increase competition. As a result of this market study, the OFT has made a recommendation to the NHS/Foundation Trusts in relation PPU partnering arrangements.

## 7 CONCENTRATION OF ANAESTHETISTS

- 7.1 Submissions received during the course of this market study have indicated that there appears to be a growing trend for consultants to form groups. In particular, there appears to be a trend for anaesthetists to form groups (AGs) and this has led to concentration of anaesthetists in parts of the UK.
- 7.2 In a number of local areas, the OFT was told that consultants form groups that work to a common fee level. The OFT consultant survey showed that 16 per cent of those who responded were part of a consultant group. Those consultants who were part of a consultant group stated that 'membership brought cost efficiencies through shared resources, gave them a more effective platform for marketing themselves to GPs and PH facilities, and provided access to a wider range of experts and professional opinion'.<sup>225</sup>
- 7.3 The legal structure of consultant groups appears to vary, ranging from legal partnerships to more informal groups that operate joint billing and equal profit sharing. From the evidence submitted during the course of the market study, it appears that the observed trend to form consultant groups, both within single PH facilities and across a local area, is especially marked for anaesthetists.<sup>226</sup>
- 7.4 It appears that anaesthetists tend to establish working relationships with surgeons, who will arrange for them to treat their patients if necessary for a particular procedure. In many cases, the PH patient may be unlikely to meet their anaesthetist before undergoing treatment, and anaesthetists appear to have little impact on the direction of the patient journey.<sup>227</sup>

<sup>225</sup> OFT consultant survey, page 76.

<sup>226</sup> Anaesthetists are qualified medical doctors who specialise in pain management, anaesthesia and intensive care medicine. Anaesthetists provide medical care to patients before, during, and after surgical procedures.

<sup>227</sup> OFT patient interviews, page 32, indicated limited interaction between patient and anaesthetist.

- 7.5 In relation to the specific benefits enjoyed by such groups, the Association of Anaesthetists of Great Britain and Ireland (AAGBI) states that typical benefits for anaesthetists working in such groups would include the division of administrative costs, shared secretarial support, an increased ability to promote and build a private practice and optimal team working with surgeons which improves patient outcomes. The OFT is also aware that typically AGs set a common fee level for their members.
- 7.6 According to a survey conducted by the AAGBI, around 44 per cent of anaesthetists active in the PH market are involved in an AG. The AAGBI submitted that the number of AGs has grown from 22 in 2006 to over 45 in 2011. This trend coincides with the observation, made by a number of PMI providers, that anaesthetists are the sub-speciality with which the PH patient is most likely to experience a shortfall.
- 7.7 The OFT has been made aware of complaints from patients which indicated situations where the anaesthetist fee being charged for the patient's treatment was not covered in full by the PMI provider and, as such, the patients would face paying a top-up fee. In some circumstances, the patients concerned could not find an alternative local anaesthetist who charged within their PMI provider's fee schedule, meaning that the payment of a top-up fee was unavoidable.
- 7.8 Furthermore, submissions to the OFT have stated that it is difficult for a patient to switch to an alternative anaesthetist. This is because patients will typically only meet their anaesthetist just before their surgery and at this point patients are unlikely to switch to an alternative anaesthetist as this would require postponing their surgery and travelling to an alternative facility located much further away to avoid paying a top-up fee.
- 7.9 During the consultation, one submission asserted that the OFT had not looked into the substantial reasons for why shortfaling and payment of top-up fees amongst anaesthetists may be more prevalent than other consultants. These reasons focused on a historical disparity between anaesthetist and surgical fees which are not justified in modern healthcare, but remain a feature of certain PMI providers' fee schedules.
- 7.10 In this first-phase, the OFT has been unable to make an overall judgment as to whether a particular PMI providers' fee schedules are too low

(especially given the variety of procedures which an anaesthetist engages in). However, the OFT stands by its initial views in relation to the greater incidence of shortfalling and the connection with a lack of information provided to patients prior to treatment. The OFT believes that the CC would – if it chooses to do so – have more capacity to examine issues over whether PMI fee schedules represent an appropriate level of reimbursement for the services that anaesthetists provide.

- 7.11 Before consulting on its consultation document, the OFT had raised with the FSA the issue of whether PMI providers should make the likelihood of consultant top-up fees and shortfalls clearer, both at the point of sale and at the time a PMI funded patient makes a claim under their PMI policy (see chapter 9).
- 7.12 Furthermore, PMI providers have provided evidence suggesting increased instances of anaesthetist bills being above PMI fee schedules amongst anaesthetists in AGs compared to the national average for anaesthetists that are not part of an AG. This indicates that anaesthetists that are part of an AG may charge higher fees than those who are not part of an AG.<sup>228</sup>
- 7.13 During the consultation, some stakeholders maintained that all consultant groups, rather than just anaesthetists, represented a cause for concern. However, in terms of evidence presented to the OFT of consumer detriment, such evidence tended to only come from situations involving anaesthetist groups. Going forward, it will be open to the CC's discretion to look into the situation in regard to all consultant groups.

### **Conclusion: concentration of anaesthetists**

- 7.14 Forty-four per cent of anaesthetists are part of an AG. Prior to, and during the course of, the market study, the OFT received a number of complaints from patients regarding their inability to find an anaesthetist who will charge within PMI provider fee schedules. These complaints have been supported by submissions and evidence from PMI providers as

<sup>228</sup> The OFT has not been able to verify, with individual anaesthetists, the actual levels of spend in comparison to the aggregate data on top-up/shortfall rates submitted by PMI providers. However, the OFT is content that the information it has been provided is sufficient for a first-stage enquiry and goes towards supporting the OFT's reasonable grounds to suspect features which prevent, restrict or distort competition.

part of the market study that high concentration of AGs in some local markets may raise prices. In the light of these complaints and following consideration of evidence in the round including consultation responses, the OFT suspects that the prevalence of AGs is also a feature of the market which may reduce price competition in local markets (particularly in view of switching costs such as the costs associated with postponing treatment or travelling to an alternative facility).

## 8 BARRIERS TO ENTRY AND EXPANSION

### Introduction

8.1 This chapter examines barriers to entry in the PH market:

- first it examines the nature of structural barriers to entry arising from the capital requirements necessary to establish a new PH facility
- the next section examines the barriers to entry that arise from the need for new entrants to gain recognition on the facility networks of the PMI providers in order to ensure the viability of a new PH facility
- finally, the chapter considers whether incentives offered to consultants by PH providers may create barriers to entry in local PH markets.

8.2 The analysis undertaken during the market study and consultation indicates that there appear to be significant barriers to entry in the PH market. This is supported by evidence that suggests that entry into the PH market has been very limited over time other than through the acquisition of existing facilities, with only one significant new entrant offering full service PH facilities in recent years.<sup>229</sup> This analysis is also consistent with recent merger decisions, where the OFT has examined the barriers to entry and expansion in the PH market, and concluded that such barriers are high enough to make the threat of entry insufficient to deter attempts to exploit existing market power.<sup>230</sup>

### Capital requirements

8.3 Submissions by PH providers to the OFT have explained that a successful new PH facility typically requires a certain level of capital

<sup>229</sup> See chapter 3 for a definition of full service PH facilities.

The new full service PH entrant, Circle, is still operating at a loss. In its Interim Report for the six months ending 30 June 2011 Circle Holdings reported an EBITDA loss before exceptional items of £6.8 million

[www.circleholdingsplc.com/uploads/document/file/21/circle\\_holdings\\_plc\\_h1\\_2011\\_interim\\_report.pdf](http://www.circleholdingsplc.com/uploads/document/file/21/circle_holdings_plc_h1_2011_interim_report.pdf)

<sup>230</sup> See, for example, Completed acquisition by Spire Healthcare Limited of Classic Hospital Groups Limited, ME/3610/08, 18 June 2008, page 20.

investment to cover its fixed costs. These costs will vary with the size of PH facility and the range of treatments it offers.<sup>231</sup> Submissions also suggest that sufficient capital is required until a PH facility is financially sustainable and this presents more of a barrier than capital for building.

- 8.4 However, stakeholder submissions during the market study also suggest that innovations in technology and clinical practice have led to a move away from treatment in an inpatient setting, as more procedures are conducted on a day case or outpatient basis and, as a result, newer PH facilities, including full service PH facilities, tend to be smaller and have lower capital requirements (see paragraph 3.24).
- 8.5 'Satellite' PH facilities built by PH providers can contain just a few rooms and basic diagnostic equipment and be located near to a competitor PH facility. The evidence suggests that this lowers the cost of entry into local markets for the larger PH providers, which are then able to channel patients from these smaller diagnostic satellite PH facilities to their full service PH facility<sup>232</sup> even if the full service PH facility is located further away than a rival PH facility.
- 8.6 It has also been suggested that partnering with a NHS PPU offers a low cost entry route into the PH market as this lowers capital requirements especially when it may involve running an existing PPU facility.<sup>233</sup>
- 8.7 However, while these developments in the market may help to lower the capital costs of establishing some new PH facilities, these costs are not insignificant. Submissions suggest that the capital investment required to build a new PH facility can range from £3 million to upwards of £25 million.<sup>234</sup>

<sup>231</sup> Estimates vary widely, but a typical figure for a two-theatre 20-bed PH facility is £21m-£25m. Smaller 10-bed PH facilities could be built for approximately £3-5m. These costs include capital expenditure, obtaining land and planning permission, and meeting regulatory requirements. One PMI provider responded during the consultation that facilities of this size may have difficulty competing with an incumbent full service facility.

<sup>232</sup> See paragraphs Annexe(s)3.22 and Annexe(s)3.23.

<sup>233</sup> PPU partnering is discussed in chapter 6 and in chapter 9.

<sup>234</sup> See footnote 230.

8.8 One of the larger PH providers submitted in its consultation response that while the increased use of day care clinics has reduced fixed costs for providing PH, these costs still constitute a significant proportion of the costs of a PH provider, and therefore lead to a high incentive for PH providers to retain work and seek incremental volumes of patients to recover these fixed costs. The OFT considers the importance of PH providers seeking patient volume to cover its fixed costs in paragraphs 8.48 and 8.50.

### **Recognition on PMI provider networks**

8.9 To be financially viable in the long term, potential new entrant PH providers need to secure income from a sufficient volume of patients to cover the cost of the investment required to enter the market and the ongoing cost of capital and equipment.

8.10 As noted in chapter 6, PMI funded patients account for 59 per cent of a PH provider's typical revenue stream on average.<sup>235</sup> Furthermore, PH providers have stated that PMI funded patients are more profitable compared to NHS patients. This means that PMI revenue is crucial for the financial viability of a new entrant.

8.11 In order to receive revenue from a PMI provider, a PH facility needs to be included on that PMI provider's networks (see Box 8.1 below). The number of networks that a PH facility is included on determines the number of PMI funded patients that a PH facility is entitled to treat.

8.12 PMI networks were originally introduced in the 1990s by PMI providers as a means to enhance their buyer power in the market. By limiting the total number of PH facilities on their networks, PMI providers would aim to negotiate lower prices from PH providers in return for network recognition of their PH facilities. In this respect, while PMI networks might exclude some PH facilities, the benefit of limiting network recognition was to drive lower prices for patients and higher efficiency. Publicly available sources suggest that in the years since the introduction

<sup>235</sup> See paragraph 6.50.

of PMI networks, the PH provider market has seen a degree of consolidation and increased concentration of the larger PH providers.<sup>236</sup>

### **Box 8.1: PMI Networks**

PMI policies include a list, or network, of PH facilities which are available to a PMI policyholder. If a PMI policyholder is treated at a PH facility listed on the relevant network, it will be reimbursed by its PMI provider.<sup>237</sup>

Most PMI providers operate a series of networks comprising (i) facility networks – these include a limited list of PH facilities at which a patient is entitled to be treated; and (ii) treatment networks – a PH provider will be added to a treatment network provided it agrees to meet a price prescribed by the PMI provider for a specific procedure.

The number of PH facilities that a PMI policyholder has access to depends on the policy which that PMI policyholder selects. In general, a low cost policy will have a more restricted PH facility network but a higher premium policy is likely to offer access to a more extensive network of PH facilities.

#### **How network recognition is granted to PH facilities**

The recognition of PH facilities on PMI networks is the subject of negotiation between PMI providers and PH providers. Such recognition is usually formalised in contracts between PH providers and PMI providers.

PH providers do not have an individual contract with a PMI provider for each PH facility within its group. The standard practice is to agree a national single network agreement including:

<sup>236</sup> Laing & Buisson, *Laing Healthcare Market Review 2011-2012*, page 80: 'During the late 1990s and start of the 2000s the acute independent hospital sector underwent a degree of consolidation as the large hospital groups expanded their portfolio of hospitals and market share, primarily through acquisition. This restructuring was facilitated by the development of hospital networks by the two major medical insurers, which threatened the stability of demand in hospitals excluded from the networks. Many non-affiliated hospitals and smaller hospital groups, which lacked the bargaining power enjoyed by the larger operators, experienced sizeable falls in patient referrals due to exclusion. As a result there were a number of hospital closures and a general reduction in capacity over the period.'

<sup>237</sup> In certain circumstances a policyholder might elect to be treated at a PH facility that is not included on the relevant network where there is a medical reason why network PH facilities are not appropriate. In these circumstances the policyholder would be reimbursed. For this and other reasons, it is necessary for PMI providers to have relationships with PH facilities which are not included on their networks.

- (i) the list of PH facilities operated by the PH provider that the PMI provider has agreed to allow its policyholders to be treated at
- (ii) the medical procedures that each PH facility is entitled to undertake
- (iii) the price that the PH provider's PH facilities are entitled to charge for each procedure.

Prices are negotiated between PH providers and PMI providers on a national basis and apply to each PH facility, although ad hoc discounts may be given by the PH provider at particular PH facilities.<sup>238</sup>

8.13 Since Bupa and AXA PPP together account for over 65 per cent of PMI funded patients, it is particularly important for a new PH facility to be included on their networks - particularly those networks which generate the greatest patient volume and revenue. This is reflected in a number of submissions by PH providers (in both the market study and consultation) and in the Laing & Buisson report which states that 'not being included on Bupa and/or AXA PPP networks could mean a significant shortfall in demand unless new PH facilities are strongly supported by self-pay patients or NHS commissioning'.<sup>239</sup>

8.14 Further, it may be important for new PH facilities to gain recognition from both Bupa and AXA PPP in order to attract consultants (and their PH patients) to the new PH facility. Evidence indicates that consultants want to treat patients at PH facilities that are recognised by all PMI providers as this gives them the widest possible pool of PH patient business. In particular, if a PH facility does not have recognition from both Bupa and AXA PPP, a consultant may decide to take their practice and patients to a PH facility that does, rather than split their work between two or more PH facilities.<sup>240</sup> This is known as the 'consultant

<sup>238</sup> One PH provider in its consultation submission highlighted that discussions on a national basis reduce what would be substantial transaction costs for negotiating for each procedure for each facility.

<sup>239</sup> Laing & Buisson, *Laing's Healthcare Market Review 2010-2011*, pages 71-72.

<sup>240</sup> This is supported by evidence from the OFT consultant survey which shows that approximately 40 per cent of consultants report that they only have admission rights to a single PH facility. Additionally, 52 per cent of consultants report that, in a typical month, they would only admit to or treat at a single PH facility. Of those consultants who indicated that they would usually treat patients at two different PH facilities, there was a strong tendency to treat most of

drag' effect – ensuring that all patients can be treated at the same PH facility.

- 8.15 One PH provider in its consultation submission noted that 'consultant drag' may have a pro-competitive effect, and in fact aid entry. A new entrant with top of the range equipment and facilities should attract PMI provider recognition as well as consultants, allowing for a rapid achievement of efficient scales of operation.
- 8.16 However, it appears that new entry has been limited in the PH market,<sup>241</sup> and those that have entered or tried to open further facilities have faced difficulties securing PMI recognition.<sup>242</sup> In addition, as examined below,<sup>243</sup> new entrants appear to often find it difficult to obtain a commitment from PMI providers to agree to recognise a new facility before undertaking the investment. This can deter both investors and consultants from signing up to a new project, such as building a new facility, making it even harder to convince PMI providers to commit to recognise a new entrant on their network. As such, new entrants can face problems co-ordinating the raising of finances with attracting consultants and PMI provider recognition for their new facility.

### **PMI network recognition as a barrier to entry**

- 8.17 As mentioned in Box 8.1, PMI providers have a range of networks, recognising different lists of facilities. PMI providers may receive requests for recognition onto a network, or, if the PMI provider is launching a new network, it may tender for recognition of facilities on this new network.

their patients at their main PH facility - more than 60 per cent of consultants said that they would treat between 70 per cent and 100 per cent of patients there.

This is also supported by evidence from one of the smaller PH providers, which noted in its consultation submission that, due to non-recognition by the larger PMI providers, their consultants do treat patients at alternative facilities.

<sup>241</sup> See paragraph 8.2.

<sup>242</sup> See paragraph 8.18 ff below.

<sup>243</sup> See paragraphs 8.18 – 8.19 below.

- 8.18 The OFT has received submissions, during the market study and consultation, from a number of PH providers, both large and small, which maintain that they are having difficulty establishing new PH facilities due to a lack of PMI provider network recognition.
- 8.19 One PMI provider submitted that it will not provide an absolute commitment to recognise a new PH facility before it has been built and any advance commitment would be contingent upon the PH facility meeting certain requirements, including: (i) attracting a reasonable spread of consultants; and (ii) resulting in a better outcome for customers based on choice, quality and cost. Difficulties in obtaining such an advance commitment may deter new entry. In particular, smaller PH provider groups state that they are unwilling to risk the costs of setting up a new PH facility without an absolute assurance of PMI provider network recognition.
- 8.20 The OFT also received a number of submissions, during the market study and the consultation, whereby PH providers, particularly smaller providers, were having difficulty securing network recognition for established facilities.
- 8.21 The majority of PH providers, both large and small, which made submissions during the consultation, argued that PMI network recognition, and the uncertainty of receiving recognition, is in itself a barrier to entry in the PH market, particularly from the larger PMI providers. One PH provider stated that network recognition is akin to a requirement to have a licence.<sup>244</sup> A number of PH providers commented further that PMI network products reduce consumer choice and restrict competition.<sup>245</sup>
- 8.22 One of the larger PH providers advocated for all facilities to be recognised by PMI providers, and that the latter should allow consumers to pay ‘top-ups’ where necessary. This PH provider argued that patients

<sup>244</sup> Two PH providers (one large and one small) also argued that the tool of recognition confers too much power on the PMI providers. Another, larger PH provider, explained that failure to receive recognition, particularly from one of the larger PMI providers was one of the reasons that led to the decision to sell their non-network recognised facilities.

<sup>245</sup> However, policyholders would be aware of their restricted choice when they bought their PMI cover, and may have benefited from lower premiums by accepting a network product.

could choose PH facilities based on quality measures. However, as set out in chapter 5 above, patients do not currently have access to comparable quality and price information to make an informed choice on PH facilities and top-up fees.

8.23 While the OFT has not undertaken a full competitive analysis of PMI networks,<sup>246</sup> the OFT is concerned that network negotiations can result in conditions that restrict new entry. In particular, the OFT has received evidence and allegations of the following practices in relation to PMI network recognition:

- 'one in all in' negotiations
- pricing threats and rebates
- other contractual provisions relating to new entry.

These practices are reviewed below.

#### 'One in all in' negotiations

8.24 Submissions from PMI providers and some PH providers state that in national negotiations with PMI providers, certain PH providers adopt a 'one in all in' negotiation tactic such that if a PMI provider wants to include one of the PH provider's PH facilities on its network it will be required to include all of that PH provider's PH facilities.

8.25 As explained in chapter 6, in order to best serve the needs of local policyholders, a PMI provider appears to have to contract with the owners of solus PH facilities. The OFT has received evidence which suggests that the PH providers which own 'solus' PH facilities have often been able to ensure that all of their PH facilities are included on the standard hospital networks of the larger PMI providers.

<sup>246</sup> The recent Laing & Buisson report holds that in regard to networks the PMI providers and larger PH providers are happy with the status quo. *Laing Healthcare Market Review 2011-2012*, page 92: 'Networks will continue as long as there is a perceived mutually beneficial outcome for insurers and hospitals/consultants, and the cost and benefit to purchasers of restricted choice for price discounts remains a popular option.'

- 8.26 This 'one in all in' practice is also sometimes reflected in an express contractual provision to the effect that all PH facilities owned by the PH provider will have network recognition and all PH facilities subsequently acquired by the PH provider will automatically receive network recognition.
- 8.27 The OFT considers that the ability of PMI providers to exclude individual PH facilities from their networks, and supplant them with others or extend their network recognition, is critical for generating price and quality competition among PH providers. The 'one in all in' negotiating tactic restricts the ability of PMI providers to exclude existing or incumbent facilities from network recognition by obliging the PMI providers to include all PH facilities of a certain provider on their networks. In local markets an obligation of continued recognition of the incumbent facilities may mean that PMI providers would be unable to direct sufficient volumes away from the incumbent to the new facility within a timescale that makes the entry viable. This has the potential to hinder the actual entry of more efficient new PH facilities. This concern has also been expressed to the OFT by PMI providers and smaller PH providers.
- 8.28 During the consultation, a number of the larger PH providers queried the OFT provisional conclusions on 'one in, all in' negotiations:
- One PH provider questioned how the recognition of new facilities would affect price and quality competition if PMI providers are unable to influence patients to switch facilities.
  - A number of the larger PH providers queried how 'one in, all in' tactics exclude more efficient competitors, as recognition does not guarantee patient volume.
  - One PH provider argued that 'one in, all in' pricing negotiations can be pro-competitive.
  - The larger PH providers argued that while they do seek to include all of their PH facilities on a PMI provider's network when negotiating, they are not always successful in doing so due to the market power of the larger PMI providers. The PH providers pointed to Bupa's delisting of GHG facilities from its standard network during their recent dispute as evidence of this.

- 8.29 As set out in paragraph 6.74 above, PMI providers have limited ability to influence patient choice between facilities. The OFT considers that by having control over the facilities on the actual network, however, the PMI providers can influence the range of facilities that patients can access. This in turn can generate price and quality competition among PH providers, and appears to have already done so. For example, information submitted during the market study, showed that when faced with the prospect of a new entrant on the network, a number of the incumbent PH providers embarked on investment and refurbishment programmes with the aim of improving the quality of their facilities.
- 8.30 Similarly, as discussed above at paragraph 8.27, it is the limitations to the ability of PMI providers to steer volume between recognised facilities that means that 'one in, all in' tactics have the potential to exclude more efficient competitors in local areas. If the PMI providers are obliged to recognise the incumbent PH facilities, it is more difficult for them to commit to directing sufficient volumes of patients to a new entrant facility within a timescale that makes the entry from a more efficient competitor viable. This has the potential to reduce competition for local markets which can only support one or two hospitals.
- 8.31 In addition, the interplay of 'one in, all in' clauses with 'alleged pricing threats' and 'other contractual provisions relating to entry', as described below, can mean that it may not be cost effective to recognise new facilities on a network.
- 8.32 Anecdotal evidence was received by the OFT demonstrating the negative consequences should a PMI provider not recognise all the facilities of a PH provider which utilises 'one in, all in' negotiations. In one instance, the PMI provider told the OFT that they lost the benefit of the price discounts negotiated for other facilities, and had to pay 'rack' rates for their policy-holders at all facilities, until the outstanding facilities were recognised onto the network.
- 8.33 One PH provider noted in its consultation submission that 'one in, all in' negotiations may have pro-competitive benefits as it guarantees a route to market for facilities, particularly smaller ones, allowing them to compete on the basis of quality and expertise. However, any such

benefits would need to be weighed up against the possible detriment that such negotiations may exclude new entrants.<sup>247</sup>

- 8.34 In the consultation responses, a number of the larger PH providers argued that PMI providers have a degree of buyer power with which they can – and do – deny network recognition to PH providers. The PH providers pointed to the recent dispute between Bupa and GHG as evidence of PMI providers’ buyer power, and the overhanging threat of delisting.<sup>248</sup> This dispute has now been resolved.
- 8.35 This example does show that Bupa, in this instance, was able to credibly delist a limited number of a GHG’s PH facilities and was able to exercise some buyer power. However, the OFT understands that Bupa suffered reputational repercussions as a result.
- 8.36 In addition, it is not clear to the OFT that delisting facilities is a credible option for other PMI providers. The OFT has received no evidence to suggest that other PMI providers would be able to exercise their buyer power in the same way. This is supported by one of the larger PH providers which acknowledged that the buyer power of the PMI providers varies significantly.
- 8.37 Also, as noted in chapter 6, it is not apparent what impact the introduction of policies with 'low cost networks' will have on the PH market and the relationship between PH and PMI providers. It is too early to assess whether these networks will be sufficient to invite new entry.

### Pricing threats and rebates

- 8.38 As noted in Box 8.1, prices for specific procedures are negotiated at a national level by PMI providers, and cover all of a PH provider's PH facilities listed on the PMI provider's networks.
- 8.39 One PMI provider alleged that, in response to its plans to include a competitor’s new PH facility on the network, a large PH provider threatened to increase its prices across all of its PH facilities in order to

<sup>247</sup> *Market Investigation References – Guidance about the making of references under Part 4 of the Enterprise Act*, March 2006, paragraph 2.29.

<sup>248</sup> See paragraphs 6.64 – 6.68.

offset any potential loss of revenue it would suffer as a result of rival entry.

- 8.40 Some contracts between PH providers and PMI providers provided to the OFT impose a price clause which is triggered in circumstances where a competing PH facility has been recognised. In some cases, there is a formula for calculating a price increase and in others recognition of a rival PH facility will result in a price renegotiation between the PMI provider and the owner of the incumbent PH facility.
- 8.41 Some PH providers and PMI providers have also suggested that PH providers use the threat of potential price increases as a means of protecting their network position with PMI providers. In this context, the OFT has been presented with allegations that PMI providers have at times agreed not to recognise a competing PH facility in exchange for the incumbent PH provider not increasing prices across its network of PH facilities.
- 8.42 The OFT has also received submissions from some PH providers which suggest that in order to gain recognition on a PMI provider's network(s), a new entrant would need to offer the PMI providers prices that are significantly lower than the larger PH providers in order to balance out any price increase that the PMI provider might suffer across the rest of the incumbent PH provider's portfolio of PH facilities as a result. Some PH providers also suggest that even offering lower prices has not secured recognition from PMI providers.
- 8.43 In addition, and separate to the pricing threats highlighted above, some contracts seen by the OFT between PH providers and PMI providers provide for retrospective rebates. A PMI provider will receive a rebate calculated according to the number of admissions or the percentage of a PMI provider's spend that is realised across the PH provider's network of PH facilities. It is possible that the imposition of loyalty rebates and discounts by PH providers might add to incentives on a PMI provider not to recognise a new PH facility if doing so would reduce any rebate payable.
- 8.44 One PH provider commented in its consultation submission that it was wrong for the OFT to say that retrospective rebates necessarily constitute loyalty rebates which may give rise to foreclosure effects, as this will depend on a case-by-case analysis. The OFT acknowledges that

each case must be considered on its individual merits. However, even if the retrospective volume rebates do not give rise to significant foreclosure effect by themselves, there is a possibility that they may contribute to barriers to entry when acting in combination with other features described in this chapter.

### Other contractual provisions relating to entry

- 8.45 The OFT has received evidence that a number of PH providers have obtained an express contractual right of veto/sign-off from the PMI providers in circumstances where the PMI provider is considering adding a new PH facility to its network. Alternatively, some contracts impose a right for a PH provider to be consulted before any new network recognition is granted to a rival PH facility.
- 8.46 The OFT has considered whether the concerns identified above could be addressed through enforcement. In principle, some may fall within the scope of the Competition Act 1998.<sup>249</sup> While the OFT would not rule out the possibility of such enforcement action should that be merited in the future, it considers that in the present circumstances enforcement action would not be appropriate to address these concerns. The OFT considers that these barriers to entry are intrinsically linked to the broader, complex and inter-related set of issues addressed in this report, and would need to be addressed as part of a holistic, in-depth examination of the market.<sup>250</sup> These reasons are examined in more detail in chapter 10.

### Assessment of harm

- 8.47 The OFT considers that the above alleged practices are capable of creating significant barriers to entry, and thereby restricting competition in the PH market. The ability of PMI providers to include new PH facilities on their networks (whether at the expense of or in addition to incumbent PH facilities) is critical for generating price and quality competition, and for driving efficiency and innovation in PH provision.

<sup>249</sup> A number of PH providers submitted during the consultation that they believed that taking forward Competition Act 1998 cases would be appropriate to address some of the concerns raised in this chapter.

<sup>250</sup> See *Market Investigation References – Guidance about the making of references under Part 4 of the Enterprise Act*, March 2006 paragraph 2.2.

Restrictions on PMI providers' ability to recognise competing PH providers are therefore likely to have a significant impact on competition in the PH market.

- 8.48 PH providers submit that if one PH facility is removed from a PMI provider's network or its patient volume drops as a result of recognition of a rival PH facility, it is reasonable to increase prices across its PH facilities due to the increased cost, on average, of treating fewer patients.<sup>251</sup> In some cases PH providers consider that recognition of a new PH facility might result in both PH facilities operating significantly under capacity, thereby requiring offsetting price increases across the PH provider's portfolio of PH facilities.<sup>252</sup>
- 8.49 However, price negotiations following the recognition of competitors can be costly for PMI providers, and may dissuade them from recognising a new facility,<sup>253</sup> or will encourage them only to recognise the facility at low enough prices to offset any price increase from the incumbent.<sup>254</sup> This behaviour, coupled with 'one in, all in' negotiations, may raise barriers to entry.
- 8.50 A number of the larger PH providers submitted during the consultation that they, like other PH providers, are keen to have all their facilities recognised, and they use their commercial acumen to the best of their ability in order to do so. Further, they do not recognise the actions described in this chapter as techniques designed to keep out new entrants, and that any barrier to entry is a result of the existence of PMI networks and not due to PH provider conduct. However, submissions received from one of the larger PH providers and a number of smaller PH providers during the consultation, while concerned about PMI network

<sup>251</sup> A number of the larger PH providers reiterated this point in their consultation submissions.

<sup>252</sup> A PMI provider also commented in the consultation that increased and excess capacity caused by a new entrant may ultimately lead to increased retail cost at both the incumbent and new entrant, causing consumer detriment.

<sup>253</sup> One of the PMI providers explicitly stated in their submission to the market study that they take into account the potential wider cost implications of recognising a competitor to a network PH provider.

<sup>254</sup> A number of smaller PH providers commented in the consultation, and the market study, that they are unable to deliver the low prices demanded by PMI providers.

recognition in general, support the OFT's concerns that the conduct of the larger PH providers keep out smaller facilities from PMI provider networks.<sup>255</sup>

- 8.51 PH providers also argue that only by ensuring that all of their PH facilities are recognised can they realise economies of scale across their network, and spread the costs of innovation and cutting edge equipment across PH facilities.
- 8.52 In general, the OFT considers that the realisation of efficiency benefits from scale and scope do not require limitations on entry, and unrestricted competition should provide the incentives for these benefits to be realised.<sup>256</sup> As noted in paragraph 8.4, a number of innovations in healthcare, coupled with a preference for outpatient and day case care, seem to be reducing the fixed costs of entry and limiting the economies of scale in PH provision, resulting in smaller clinics. These developments appear to reduce the justification of efficiency benefits that may result from limiting new entry and make it important to encourage new entry and innovation.
- 8.53 Further, while the OFT recognises that the realisation of economies of scale may produce offsetting customer benefits, the OFT is uncertain as to whether such benefits are passed on to consumers through lower prices, or will exacerbate the adverse affect on competition by entrenching the incumbent providers. The OFT believes that the CC will be best placed to weigh this up.
- 8.54 Moreover, as noted in chapter 5, patients are currently not in a strong position to drive competition in local markets given the shortage of standardised, comparable quality information on PH facilities in the market, and the absence of price sensitivity among PMI funded patients. The OFT considers that this makes it all the more important that the ability of PMI providers to drive competition between PH providers through network recognition is unencumbered.

<sup>255</sup> Documentary evidence submitted by some of the PMI providers during the market study also illustrate incidents of covert threats of price increase if a competitor was recognised, and contractual automatic network recognition.

<sup>256</sup> Unless there are very specific reasons why this may not be the case. No special reasons appear to apply to this market.

## Consultant incentives

8.55 This section considers how the need to attract consultants to treat patients at a new PH facility may constitute a barrier to entry. It further sets out how incumbent PH providers appear to offer consultants incentives which could serve to raise barriers to new PH provider entrants.

### The importance of consultants to PH providers

8.56 Consultants are very important to PH providers given that patients are usually referred by their GPs to a consultant rather than a PH facility. Evidence also indicates that a patient is unlikely to change consultant in order to get a different choice of PH facility.<sup>257</sup> It is therefore mainly consultants who bring patients into a PH facility and generate revenue for it.

8.57 As noted in paragraph 3.19 above, consultants usually choose to focus their work at one main PH facility. Competition to be a consultant's main PH facility is high because consultants are able to 'drag' patients towards PH facilities since some consultants seem reluctant to split their practices across PH facilities (as explained in paragraph 8.14 above).

8.58 Therefore, it is important for PH facilities to attract and retain consultants and this appears to be an important dimension of competition between PH providers at the local level.

8.59 The OFT has received evidence that the two most important factors influencing a consultant's choice of PH facility are quality and convenience.

8.60 In relation to convenience, the OFT's consultant survey showed that 96 per cent of private consultants hold an NHS post and only attend to their private practice outside of their NHS contracted hours. Therefore consultants tend to choose a PH facility that is close to the NHS facility

<sup>257</sup> As explained in paragraphs Annexe(s)3.17 to Annexe(s)3.19.

where they practice.<sup>258</sup> The location of a PH facility may therefore be an important element of competition between PH providers at a local level.

8.61 The OFT consultant survey also showed that one of the reasons why a consultant chooses one PH facility over another is how the PH facility manages the administrative burdens faced by consultants.<sup>259</sup> Administrative support, such as a streamlined billing process or secretarial support, is an important aspect of a PH facility's offering to consultants, and PH providers can offer specific administrative incentives to attract consultants (see below).

8.62 In addition, PH providers offer direct and indirect financial incentives to consultants. These are reviewed below.

### Types of consultant incentives

8.63 Given the ability of consultants to provide a regular flow of patients, some PH providers adopt a strategy of incentivising consultants to treat patients at their PH facilities. The OFT has identified a number of incentives offered by PH providers which range from indirect financial incentives, such as:

- free or discounted consultation rooms
- free or discounted administrative staff

to direct financial incentives, such as:

- bonus payments contingent upon a volume target being met
- annual bonus payments calculated as a percentage of the revenue that the consultant generates for the hospital group in question
- loyalty payments which reward consultants for treating a higher proportion of their patients at a facility

<sup>258</sup> The OFT consultant survey shows that for 85 per cent of consultants surveyed the travel time between their main PH facility and their main NHS facility was between 0 and 30 minutes.

<sup>259</sup> OFT consultant survey, page 65.

- an equity stake in the PH facility, offering consultants a share in the profit of the PH facility in exchange for a commitment to treat a certain percentage of their patients at the PH facility.
- 8.64 Indirect incentives are widespread in the market.<sup>260</sup> All PH providers that submitted evidence to the OFT offer some form of non-financial incentives to their consultants.
- 8.65 A small number of PH providers indicated that they offered direct financial incentives to attract consultants,<sup>261</sup> while a number of other stakeholders suggested that direct financial incentives are available to consultants, particularly in London (although the OFT has not tested this).
- 8.66 In addition, the OFT has received copies of contracts between some PH providers and consultants which contain clauses which make the availability of incentives (whether direct or indirect) subject to a requirement on the consultant not to treat patients at a competing PH facility or subject to the consultant not obtaining an equity interest in a competing PH facility. Certain submissions also allege that the possibility of new entry results in some PH providers proposing to withdraw consultants' practising privileges (and in some cases actively withdrawing practising privileges) if they treat patients at the new, competing, PH facility.
- 8.67 The availability of volume based bonuses or payments from one PH facility might also have the effect of an exclusivity provision given that consultants often prefer not to split their patient lists between two PH facilities. Thus, although a consultant might be contractually free to treat patients at another PH facility, he or she may be disincentivised to do so in circumstances where this would result in foregoing a loyalty payment.

<sup>260</sup> The OFT consultant survey, pages 65-66, shows that consulting room prices can be an influential factor for why a consultant may switch (or consider switching) between main PH facilities.

<sup>261</sup> The OFT consultant survey shows that consultants typically had not entered into any agreements with the PH facilities at which they possessed admission rights (85 per cent). The remaining consultants had entered into agreements of varying types with no more than one or two per cent of respondents in each case highlighting a specific form of agreement, indicating that they were uncommon.

8.68 One of the larger PH providers commented in their consultation submission, in reference to the OFT consultant survey at footnote 260, that the use of financial incentives does not appear to be widespread. However, the OFT consultant survey is only a snapshot of the industry and while currently only 15 per cent benefited from financial incentives, a much greater percentage cited financial incentives as an influential factor should the consultant switch facilities.<sup>262</sup> Further, the OFT has received anecdotal evidence of a range of consultant incentives, and has broad concerns about the resultant effect on the patient journey and potential foreclosure.<sup>263</sup>

### Consultant incentives as a barrier to entry

8.69 If a new PH facility is unable to attract consultants in a local market, whether as a result of exclusivity provisions or from a consultant's desire not to forego bonus payments from the incumbent PH facility, then where the incumbent has market power the new PH facility may have difficulty entering the local market.

8.70 Several PH providers have provided evidence that they will not open a PH facility or expand an existing PH facility without first obtaining commitments from consultants that they will treat patients at that PH facility. Indeed, as noted in paragraph 8.19 above, PMI providers can make it a condition of an advance commitment to recognise a new PH facility that the new facility has attracted a reasonable range of consultants. If an incumbent PH provider is able to tie up the available consultants, new entry will be more difficult.

8.71 In principle, an efficient new PH facility could offer similar or better incentives to attract consultants away from incumbent local PH facilities.<sup>264</sup> However, as noted in paragraph 8.14 above, many consultants are unwilling to split their private treatment lists between two or more PH facilities (the 'consultant drag' effect). If the incumbent

<sup>262</sup> OFT consultant survey pages 65-66.

<sup>263</sup> Consultation submissions from a PH provider and a PMI provider also concur that there are a range of measures that may discourage a new entrant, and that there may be further latent types of conduct which may raise concerns.

<sup>264</sup> See paragraph 8.15 above.

PH provider enjoys local market power and thereby already accounts for a high proportion of consultants' PH treatments, loyalty payments or exclusivity provisions imposed by the incumbent PH provider are likely to exacerbate this drag effect, by further incentivising consultants to treat all their private patients at the incumbent PH facility. In this way, new entrants may have difficulty attracting consultants even with similar incentive schemes.

- 8.72 The OFT therefore considers that where consultant exclusivity or loyalty is encouraged or required by PH providers with local market power using direct or indirect financial incentives this may create further barriers to entry in the PH market as this reinforces the consultant drag effect, drawing consultants away from new entrants or other PH providers. A number of PH providers submitted during the consultation that a PH provider does not need local market power to encourage commitment of consultants, and potentially create a barrier to entry, and this is an issue that the CC may wish to consider further.
- 8.73 In addition, one of the larger PH providers argued in their consultation submission that some financial incentives encouraging consultant loyalty may have pro-competitive effects, such as new services and clinical developments as a result of co-investments or joint ventures between the PH provider and consultants. However, another of the larger PH providers has argued in the opposite, and called for a complete ban on direct financial incentives to consultants, as it prevents competition on the merits and can be a barrier to entry and/or expansion for those PH providers who do not offer such incentives.
- 8.74 Other types of consultant incentives, which encourage PH facilities to compete for consultants on the basis of superior quality of PH facilities, such as buying new equipment or investing in facilities, better care and services, or administrative support are unlikely to present competition concerns. This type of competition for consultants should be able to be offered by equally efficient competitors, and is likely to encourage PH providers to innovate in the way that they offer care and, as a result, may generate longer term benefits for patients.
- 8.75 A number of the larger PH providers submitted during the consultation that the OFT has not clarified which consultant incentives are pro-competitive, and which are anti-competitive. The OFT, in this first phase,

has not undertaken a thorough examination of effects on competition of each individual type of incentive, but has concerns that they may operate to dampen competition in this market. This may be an area which the CC wishes to consider further.

- 8.76 One PH provider suggested that PMI providers also offer consultant incentives, which operate as barriers to entry. For example, Bupa offered<sup>265</sup> a voluntary Consultant Partnership Scheme whereby consultants who charged within the benefit maxima for all treatment fees apart from outpatient consultations, received from Bupa a retrospective annual bonus of 10 per cent of the consultant's charges on Bupa members for that year (excluding consultation fees), depending on the treatment and the consultant's speciality. Bupa has suggested that such schemes help PMI providers deliver affordable healthcare to policy-holders as they ensure there are no shortfalls. The OFT has not assessed the prevalence or impact on competition of PMI provider consultant incentives, although this may also be an area the CC may wish to consider further.
- 8.77 A number of respondents also commented in the consultation that the need for consultants to be recognised by PMI providers (as well as the individual facility), and the terms of recognition, can be a barrier to entry to the PH sector. However, Bupa has submitted, that even with new consultant recognition schemes, the numbers of consultants applying for, and receiving recognition remains high.<sup>266</sup> The OFT has not undertaken an analysis of the impact on competition of these schemes and the CC may wish to consider it further.

## **GP incentives**

- 8.78 The OFT has received limited evidence of some PH providers with local market power also potentially seeking to tie in GPs by means of referral incentives and requirements. In particular, the OFT has been presented with copies of contracts between PH providers and GP surgeries under

<sup>265</sup> This scheme was closed to new members in 2010.

<sup>266</sup> As one PMI provider noted, referring to the OFT consultant survey (Figure 3.49 page 48), there appears to be no constraint on supply as 58 per cent of consultants surveyed said they had extra capacity.

which the PH provider acts as landlord to a GP surgery and appears to incentivise the GP surgery to make referrals to that PH provider by offering discounted rent in exchange for patient referrals. The OFT has also received evidence of a scheme under which a PH facility pays GP surgeries for carrying out pre-operative assessments on patients provided that the patient is subsequently treated at one of the PH provider's facilities.

- 8.79 Although this evidence is limited to some isolated instances, given the importance of the role of the GP in the referral process, the OFT considers that any such referral incentives and requirements imposed on GPs by PH providers with local market power have the potential to distort competition in ways similar to analysis of consultant incentives above. All the consultation submissions which responded on this issue, opposed the use of incentives for GPs.

### **Conclusion: barriers to entry and expansion**

- 8.80 The OFT considers that a number of features of the PH market combine to create significant barriers to entry. These are:
- Certain conditions imposed by larger PH providers as part of the recognition of their facilities on PMI networks which may restrict the ability of PMI providers to recognise new entrants attempting to offer competing PH services on their networks. For example, some PH providers impose conditions on PMI providers that they be consulted on the recognition of a new entrant on a PMI providers' network, or that impose price rises on a PMI provider should a new entrant be recognised.
  - A combination of the need for wide PMI network recognition and the 'consultant drag' effect. As many consultants prefer to treat most of their private patients at one main PH facility, and patients are insured by different PMI providers, new entrants need to be recognised on all of the main PMI networks in order to attract a sufficient number of consultants to practice at their facility.
  - Incentives paid directly or indirectly by PH facilities to consultants to encourage them to treat all, or a higher number, of their patients at their facility. These incentives may further discourage consultants

from treating patients at the facilities of new entrants, attempting to offer competing PH services.

- In addition, in this context, the OFT notes the possibly emerging trend of the provision of financial incentives to GPs by PH providers with local market power, in order to encourage those GPs to refer patients to the PH provider's facilities. This trend may also have the potential to develop as a barrier to entry.

8.81 The OFT notes that many of these features are intrinsically linked to the other aspects of this market examined in chapters 5 and 6. For example, the shortage of comparable quality information on PH facilities, examined in chapter 5, may make it harder for new PH provider entrants to establish a reputation for quality in the market by which to attract consultants and patients away from incumbent PH providers.<sup>267</sup>

<sup>267</sup> Although a number of submissions considered that it was the relationship between the PMI and the larger PH providers and addressing the information asymmetries would not resolve the issues regarding concentration and barriers to entry.

## 9 OTHER STUDY FINDINGS

### PMI provider transparency

- 9.1 As set out in chapter 5, the OFT has found evidence of variable practice as to how and when consultants communicate prices to PMI funded patients.<sup>268</sup>
- 9.2 In most instances, the lack of discussion on fees prior to treatment does not give rise to any difficulty for the patient, as this fee will fall within the PMI providers' fee schedules and the PMI provider will pay for all the treatment. However some consultants charge fees in excess of a PMI provider fee schedule, leaving the PMI funded patient in a position where they may have to pay an unexpected shortfall to the consultant.
- 9.3 As set out in chapter 7 above, the evidence received from the market study shows that anaesthetists are the most likely group of consultants to shortfall patients. Anaesthetists are also the group most likely to have no contact with patients prior to the operating theatre,<sup>269</sup> and formation of AGs may reduce price competition in certain local markets.
- 9.4 As a result of concerns expressed by consumers in relation to extra payments sought by some medical practitioners when costs are not completely covered under PMI policies, the OFT has raised this issue with the FSA during the course of this market study. As a result, the Association of British Insurers (ABI) has confirmed to the FSA, on behalf of its members, that PMI providers will either cover the total cost so that no shortfall arises, or make clear the possibility of a shortfall due to limits which apply to the amount payable under their policies, both at the point of sale and at the time a consumer makes a claim under the PMI policy.

### PPU partnering

- 9.5 As set out in chapter 6 above, the evidence gathered during the market study highlights an increasing trend for PPUs to 'partner' with PH

<sup>268</sup> See paragraph 5.58.

<sup>269</sup> See paragraph 5.60.

providers. This may not in itself cause concern unless the arrangement is likely to increase concentration which may lead to a reduction in competition. The OFT proposes to ask the CC to consider this issue further as part of the proposed market investigation reference.

9.6 Certain PPU partnering arrangements may qualify for review under the merger provisions set out in Part 3 of the Enterprise Act 2002, depending on the nature of the arrangements in each case.<sup>270</sup> In this context, the OFT recommends that parties entering into PPU partnering arrangements assess whether the arrangement may qualify for merger review. Given the UK's 'voluntary' merger regime, there is no requirement to notify mergers to the OFT, and parties are able to decide themselves whether they wish to proceed with a transaction without first obtaining regulatory approval.

9.7 However, the OFT can make inquiries of its own initiative where it believes that it may have jurisdiction and it has a dedicated Mergers Intelligence Officer responsible for monitoring non-notified merger activity. The OFT is able to call such non-notified cases in for a review at any point up to four months after the merger has completed (or was 'made public', if that occurs later). As a result, parties should be aware that proceeding with a transaction that may qualify for merger review and raise competition concerns does carry certain risk: see paragraphs 4.21 to 4.24 of the OFT's mergers guidance.<sup>271</sup> Parties to a merger and their advisers may approach the OFT for informal advice about the OFT's views of jurisdictional and competition issues in a future transaction. Pre-notification discussions are also available where the parties wish to proceed to notify a merger.<sup>272</sup>

<sup>270</sup> The Enterprise Act 2002 merger provisions apply to 'relevant merger situations', which occur when two or more 'enterprises' 'cease to be distinct' and the transaction or arrangement meets either a turnover test or share of supply test. For guidance on what the OFT will consider to be a relevant merger situation see *Mergers – Jurisdictional and Procedural Guidance*, June 2009 OFT527, chapter 3.

<sup>271</sup> *Mergers – Jurisdictional and Procedural Guidance*, June 2009 OFT527.

<sup>272</sup> For further information on the availability of informal advice and pre-notification discussions see *Mergers – Jurisdictional and procedural Guidance*, June 2009, OFT527, chapter 4.

## Competitive neutrality

- 9.8 As set out in chapter 4, PH providers believe that PPUs have a number of competitive advantages such as potential access to existing NHS infrastructure, facilities and staff.
- 9.9 The OFT has not sought to establish whether such advantages exist in relation to the provision of PH but considers that there should be a 'level playing field' between state-owned enterprises, private firms and third sector organisations in mixed markets, known as the 'competitive neutrality' principle.
- 9.10 The significance of establishing competitive neutrality is clear. Where competitive differences do not reflect underlying differences in costs or objectives – such as where regulations or taxes apply differently to private, public and third sector providers – there is a risk that the market will not operate effectively due to resources being used inefficiently. This could potentially lead to higher prices and reduced value for taxpayers.
- 9.11 One consultation response from a larger PH provider supports the OFT's statements regarding the need for competitive neutrality between private and public providers in the PH market.
- 9.12 The OFT would therefore urge Foundation and NHS Trusts to consider the competitive neutrality principle when deciding on how they seek to tailor their prospective PPU arrangements with PH providers in order to ensure that the 'partner' does not obtain an unfair advantage over other PH providers. The OFT suggests that this can be achieved by ensuring both the PPU and the PH provider 'partner' pay a market-consistent rate of return (ROR) on the assets they use for providing the relevant activities. A market-consistent ROR would be one that is comparable with what is earned by the majority of firms within the same industry.<sup>273</sup>

<sup>273</sup> Further information can be found in OFT working paper, *Competition in Mixed Markets: ensuring competitive neutrality*, July 2010, OFT1242.

## 10 FEATURES OF THE MARKET WHICH PREVENT, RESTRICT OR DISTORT COMPETITION

10.1 The OFT has reasonable grounds for suspecting that there are features of the PH market, which, individually or in combination, prevent, restrict or distort competition in connection with the supply or acquisition of PH services in the United Kingdom. Section 131(2) of the Enterprise Act 2002 states that a feature of a market is to be construed as a reference to:

- the structure of the market concerned or any aspect of that structure
- any conduct (whether or not in the market concerned) of one or more than one person who supplies or acquires goods or services in the market concerned or
- any conduct relating to the market concerned of customers of any person who supplies or acquires goods or services.<sup>274</sup>

10.2 The threshold test in section 131 requires the OFT to have reasonable grounds only to suspect that there are features of a market that may restrict, distort or prevent competition. While the OFT accepts that it has a discretion whether or not to make a reference in circumstances where the threshold test is satisfied, this is exercised within the context of the first phase enquiry.

10.3 The OFT is satisfied that it is appropriate, following this first phase enquiry, for there to be a detailed investigation of this market, and the appropriate body to carry out that investigation is the CC. The making of this MIR does not imply any pre-judgment as to what the CC's findings or conclusions will be.<sup>275</sup>

<sup>274</sup> Section 131(3) of the Enterprise Act 2002 notes that conduct includes any failure to act and any unintentional conduct.

<sup>275</sup> The OFT notes previous remarks by Sir Christopher Bellamy, the then President of the Competition Appeals Tribunal, in the appeal of the Association of Convenience Stores (ACS) v OFT in 2005 in relation to the nature of the test in Section 131 EA02. He stated,

- 10.4 For the reasons given in the preceding chapters, and having fully considered the submissions made as part of the OFT's consultation, the OFT has identified the following features:
- 10.5 **Information asymmetries:** As analysed in chapter 5, the OFT considers that there is a shortage of accessible, standardised and comparable information provided to patients and their advisors in relation to the quality of PH facilities and of consultants. There also appear to be difficulties for PMI funded patients in assessing the risk of shortfall from particular consultants, whereby a consultant's fees exceed the benefit maxima that the patient's PMI provider will reimburse resulting in the potential for an additional payment by the patient. In addition, for self-pay patients, there are difficulties in easily comparing the prices charged by different PH facilities.
- 10.6 In general, the OFT considers that this shortage of accessible, standardised and comparable information weakens the ability of patients and GPs to drive efficiencies and stimulate enhanced competition between rival PH facilities and between consultants, and may give rise to a dampening of competition in the market overall. The lack of access to information on quality and price for consultants appears to produce a situation where both the patient and PMI provider cannot differentiate between consultant performance and fees in order to judge whether they represent value for money. This may be preventing the development of more flexible, less distortive methods for PMI providers to control consultant costs, whereby patients can choose between consultants on the basis of their respective fees and quality and pay a top-up fee to the consultant, above the maximum provided by their insurance cover, if a patient judges it to be worthwhile.
- 10.7 Finally, the OFT notes that information asymmetries are a factor across a number of other features examined in this report, including the limits on the ability of PMI providers to exercise buyer power which is examined in chapter 6. The lack of access to comparable quality information on PH facilities may also facilitate a competitive dynamic whereby competition between PH providers is based less on the quality of services provided to

'Is it not the intention that for the first phase, the OFT stage, is not intended to be a deep and prolonged investigation in which every avenue is exhaustively looked at? That is for the CC stage.' ACS v OFT: Case Management Conference (2005).

patients and, since a consultant often effectively seems to choose at which PH facility the patient is treated, more on attracting consultants to their PH facilities through the use of a variety of contractual and non-contractual incentives. This may increase the cost of PH without necessarily driving improvements in the quality of services provided to patients. The development of consultant incentives is examined in chapter 8.

- 10.8 **Concentration:** PH provision appears to be concentrated at the national level. At the local level there appear to be examples of extreme concentration, such as areas where there is no alternative fascia PH facility within a 30-minute drive time of a particular PH facility (solus PH facilities). In addition, the OFT notes widespread concerns raised in submissions in response to the consultation document about the existence of 'must-have' facilities. While the OFT has not taken a definitive view on whether particular faculties are 'must have', it considers that there are likely to be a number of local markets with a high degree of concentration, such as those areas with only two PH facilities within a 30-minute drive time.
- 10.9 For the reasons set out in chapter 6, including the desire of patients to be treated locally, there are reasonable grounds to suspect that these levels of concentration restrict competition in the provision of PH.
- 10.10 The purchasing of PH provider services is also concentrated at the national level. The size of the largest PMI providers appears to provide them with some buyer power in that PH providers are, to an extent, dependent on access to, and inclusion on, the networks of these larger PMI providers for the financial viability of their PH facilities. The emergence of 'low cost' PMI networks, open referrals and the recent delisting of hospitals by one of the largest PM providers support the existence of some buyer power at least among the largest PMI providers.
- 10.11 However, there may be limits on the PMI providers' ability to exercise such buyer power. Firstly, the degree of any such buyer power is likely to vary by size of the PMI provider in terms of its share of subscription income, and it is likely that not all PMI providers are large enough, on this basis, to exercise buyer power. Secondly, any buyer power may be constrained by the need for PMI providers to purchase PH in most local markets, including areas with solus PH facilities as described above, in

order that their policyholders can be treated locally. Thirdly, PMI providers are likely to face at least some reputational costs if they carry out a threat to delist or exclude PH facilities from PMI networks. Further, beyond the exclusion of PH facilities from their networks, PMI providers have limited ability to direct patients to different PH facilities since in most cases GPs rather than PMI providers recommend the consultants, and consultants often determine a patient's choice of PH facility.

- 10.12 The OFT notes that the development of partnership arrangements between the PPUs of NHS/Foundation Trusts and PH providers has the potential to either exacerbate or alleviate any concentration concerns in local PH markets. Local market concentration may increase if a PH provider that is already present in the local market partners with the PPU. This is because the partnering arrangement may lessen the competitive constraint on the relevant PH provider offered prior to the partnering arrangement and reduce choice for PH patients and PMI providers. On the other hand, a partnership arrangement between a PPU and a new PH provider in the local market has the potential to provide a platform for entry and thereby to increase competition. As a result of this market study, the OFT has made a recommendation to the NHS/Foundation Trusts in relation PPU partnering arrangements.
- 10.13 **Concentration of anaesthetists:** As examined in chapter 7, 44 per cent of anaesthetists are part of an AG. Prior to, and during the course of, the market study, the OFT received a number of complaints from patients regarding their inability to find an anaesthetist who will charge within PMI provider fee schedules. These complaints have been supported by submissions and evidence from PMI providers as part of the market study that high concentration of AGs in some local markets may raise prices. In the light of these complaints, the OFT suspects that the prevalence of AGs is also a feature of the market which may reduce price competition in local markets (particularly in view of switching costs such as the costs associated with postponing treatment or travelling to an alternative facility).
- 10.14 **Barriers to entry:** For the reasons analysed in Chapter 8, the OFT considers that a number of features of the PH market combine to create significant barriers to entry. These are:

- Certain conditions imposed by larger PH providers as part of the recognition of their facilities on PMI networks which may restrict the ability of PMI providers to recognise new entrants attempting to offer competing PH services on their networks. For example, some PH providers impose conditions on PMI providers that they be consulted on the recognition of a new entrant on a PMI providers' network, or that impose price rises on a PMI provider should a new entrant be recognised.
- A combination of the need for wide PMI network recognition and the 'consultant drag' effect. As many consultants prefer to treat most of their private patients at one main PH facility, and patients are insured by different PMI providers, new entrants need to be recognised on all of the main PMI networks in order to attract a sufficient number of consultants to practice at their facility.
- Incentives paid directly or indirectly by PH facilities to consultants to encourage them to treat all, or a higher number, of their patients at their facility. These incentives may further discourage consultants from treating patients at the facilities of new entrants, attempting to offer competing PH services.
- In addition, in this context, the OFT notes the possibly emerging trend of the provision of financial incentives to GPs by PH providers with local market power, in order to encourage those GPs to refer patients to the PH provider's facilities. This trend may also have the potential to develop as a barrier to entry.

10.15 The OFT notes that many of these features are intrinsically linked to the other aspects of this market examined in chapters 5 and 6. For example, the shortage of comparable quality information on PH facilities, examined in chapter 5, may make it harder for new PH provider entrants to establish a reputation for quality in the market by which to attract consultants and patients away from incumbent PH providers.<sup>276</sup>

<sup>276</sup> Although a number of submissions considered that it was the relationship between the PMI and the larger PH providers and addressing the information asymmetries would not resolve the issues regarding concentration and barriers to entry.

10.16 It is the OFT's view that the section 131 test for making a reference is met in relation to these features and, therefore, the decision on whether to make a reference rests on the exercise of the OFT's discretion.

### **Appropriateness of a reference**

10.17 The OFT's guidance on market investigation references<sup>277</sup> sets out four criteria, all of which must be met before the OFT will exercise its discretion to make a reference to the CC.

- alternative powers: it would not be more appropriate to deal with the competition issues identified by applying the Competition Act 1998 (CA98) or using other powers available to the OFT or, where appropriate, making recommendations to sectoral regulators
- the scale of the suspected problem: the adverse effect on competition is significant, such that a reference would be an appropriate response to it
- availability of remedies: there is a reasonable chance that appropriate remedies will be available
- undertakings in lieu of a reference: it would not be more appropriate to address the problem identified by means of undertakings in lieu of a reference.

10.18 The OFT's assessment of each of these four factors follows.

#### **Alternative powers**

10.19 The OFT has considered whether some of the possible concerns identified could be addressed more appropriately through enforcement and/or through recommendations to industry, regulators and Government.

10.20 When considering if the issues identified are more appropriately addressed through enforcement, it is the OFT's policy to consider first whether the issues may involve an infringement of one or both of the

<sup>277</sup> *Market Investigation References – Guidance about the making of references under Part 4 of the Enterprise Act*, March 2006.

CA98 prohibitions or Article 101 and/or 102 and whether to investigate accordingly.

- 10.21 Based on the information received in this market study and in response to the consultation, the OFT has considered whether the barriers to entry identified in chapter 8 that result from PMI network recognition, or from certain consultant financial incentives offered by PH providers, may be addressed more appropriately through enforcement action.
- 10.22 The OFT considers that these barriers to entry are intrinsically linked to the broader, complex and inter-related set of issues addressed in this report, and would need to be addressed as part of a holistic, in-depth examination of the market.<sup>278</sup> In addition, the OFT notes that enforcement action would not be appropriate to address issues around information asymmetry which is a key concern identified in this report.
- 10.23 However should any party bring evidenced allegations of anti-competitive conduct relating to the PH sector to the attention of the OFT then it will consider whether any enforcement action should be prioritised.
- 10.24 It is possible that during a second phase enquiry, the CC uncovers evidence which may identify competition infringements and which the CC would remit to the OFT for consideration. The OFT would be keen to consider whether to prioritise any such evidenced infringements as soon as possible thereafter.
- 10.25 The OFT has also considered whether the issues it has identified could be more appropriately addressed through recommendations to Government Departments, health regulators or other sectoral bodies.
- 10.26 In relation to the features of concentration and barriers to entry, the OFT considers that it would not be possible to address the concerns identified in this way. In relation to the feature of information asymmetries, while the OFT welcomes the willingness among some industry participants to improve the availability of accessible, comparable information on quality, the OFT does not consider that there is sufficient consensus among all

<sup>278</sup> *Market Investigation References – Guidance about the making of references under Part 4 of the Enterprise Act, March 2006 (see 2.2).*

the necessary sectoral bodies and industry participants such that its concerns could be addressed through voluntary recommendations.

- 10.27 In particular, after considering consultation submissions, the OFT remains concerned that – whilst moving in the right direction – it is not yet clear whether the self-regulatory Hellenic Project will be robust enough to ensure the provision of appropriately standardised, comparable information and the OFT believes that allowing the CC to examine this area will allow the requisite in-depth analysis of the information needs of patients and their advisors when considering PH treatment
- 10.28 During the consultation, one PH provider asserted that the CQC – via its powers and remit under the Health and Social Care Act 2008 (HSCA) – is well placed to address concerns about information asymmetries as identified by the OFT. In particular, this submission proposed that, following a recommendation from the OFT, the CQC would be able to develop further guidance for PH providers on the provision of information via its powers under section 20 of the HSCA. PH providers would need to comply with this guidance in order to maintain their registration under the HSCA, and this would negate the need for a MIR to the CC.
- 10.29 Prior to the publication of the consultation document, the OFT had met with the CQC to discuss its role in relation to information issues. However, following receipt of this particular submission, the OFT asked the CQC to further elaborate what its powers under the HSCA would enable it to achieve in relation to the OFT’s concerns. Specifically, the OFT asked the CQC to consider each of the OFT’s potential measures as identified at 10.42 below in turn, and comment on whether it would be able to compel providers to make this information available via its HSCA powers. On each of these measures, the CQC confirmed that it did not have power to act in the manner suggested by the PH provider, and could not compel the provision of such information.<sup>279</sup>

<sup>279</sup> Specifically, the CQC confirmed that regulation 17 of the Health and Social Care Act 2008 Regulations 2010 did not require the publication of specific information to service users. Furthermore, in relation to regulation 19 which focuses on prices and payment, the CQC confirmed that it could not mandate the exact timing nor exact content of any statement of costs. A further complicating factor would be that the consultant is not necessarily the registered person in respect of the regulations, as in most large PH facilities they act in a similar way to a sole trader, whereby they are granted a right to practice in that PH facility.

- 10.30 The CQC did confirm that under section 20 of the HSCA, the Secretary of State may be able to make further regulations directed at ensuring that certain information is made available to patients. In respect to this final point, the OFT believes that, given the complexity of these issues and continued uncertainty on the exact nature of information required, it is necessary to further explore what would be contained in any such recommendation to the Secretary of State. As a result, the OFT considers that any recommendation to the Secretary of State would (if it is found to be appropriate) be more effective following a more detailed investigation by the CC.
- 10.31 Finally, this report does make three specific recommendations in Chapter 9 to address particular issues that arose in the course of the market study. The OFT does not propose these as solutions to the features identified above.

### Scale of the problem

- 10.32 The OFT considers that a reference would be an appropriate response in this market given the scale of the suspected problems identified. This view is reached for two reasons. First, the size of the market is significant and estimated to be approximately £4.92 billion. There is also scope for this market to grow in the future in line with an ageing UK population and a consequent growth in the demand for healthcare provision.
- 10.33 A number of the larger PH providers submitted consultation responses that the OFT had not established the scale of the problem on the grounds that the consultation document does not identify all the competitive constraints which act upon PH providers, or the benefits arising from current levels of competition in PH provision. One of the larger PH providers also considered that the consultation document fails to provide sufficient evidence of harm, such as prices above competitive levels.
- 10.34 The OFT recognises that the PH market clearly provides a valuable service to patients and patients benefit from the general quality of PH provision and the convenience of having local facilities that investment in PH has brought. The question, however, is whether the features

identified in this report are preventing the PH market from working even better in the interests of patients.

- 10.35 As noted in chapter 6, the OFT has not undertaken detailed pricing and quality analysis, and considers it would be inappropriate to do so as part of a first phase enquiry. However in the OFT's view, the adverse effects of the features it has identified may well be significant, possibly leading to higher prices for PH through higher PMI premiums and limiting choice for patients. The features could also be deterring new entry, meaning that these effects are exacerbated.
- 10.36 In particular, the combination of information asymmetries, high concentration and barriers to entry in the PH market appears to result in reduced choice for patients. It may also restrict competition between PH providers and between consultants by impairing the ability of patients, GPs and PMI providers to choose between competing service providers, including new entrants, on the basis of superior quality and better value for money. This might be expected to result in higher prices and lower quality of services for patients and innovation in the PH market. The consumer harm that the features generate affects all PH patients to some extent
- 10.37 Finally, the identified features suspected of adversely affecting competition are unlikely to be short-lived. In this context, it is worth noting that potential issues relating to information asymmetry, concentration and barriers to entry in the market for PH in the UK have been noted in previous market and merger analyses of the OFT and CC dating back to 1994.

### Availability of remedies

- 10.38 A number of the larger PH providers made submissions during the consultation that a MIR would be inappropriate at this time due to the passage of the Health and Social Care Bill (the Bill) and the changes to the role of PH in the provision of NHS healthcare it may bring. Some submitted that this will put the market in flux and as such the CC would be unable to assess which, if any, remedies may be suitable to address any adverse effects on competition it identified.
- 10.39 The OFT considers that while certain aspects of the Bill may have an impact on the PH market the primary impact of the Bill will be on the

NHS, and not on the PH market. Furthermore, to the extent that PH providers already provide services to the NHS, or that the NHS provides private services through PPU, the reforms proposed in the Bill may result in a continuation of this trend rather than any significant new or unanticipated change. As such, the CC would be able to anticipate resulting changes in the PH market sufficiently to be able to assess which, if any, remedies may be suitable to address any adverse effects on competition identified.

- 10.40 It is not for the OFT in a market study to determine which remedies would or would not be appropriate. In the context of the first phase enquiry the OFT is required to assess whether there is a reasonable chance that appropriate remedies would be available to the CC if it finds one or more adverse effects on competition in this market. In the event of a reference, it is for the CC to perform an independent investigation to decide whether there is an adverse effect on competition and if it finds that there is, to decide what remedy or remedies it can put in place to achieve as comprehensive a solution as is reasonable and practicable to any adverse effects and any detrimental effects on customers identified.
- 10.41 Nevertheless, over the course of the market study, the OFT has developed a detailed understanding of the PH market and given considerable thought to the market features it has identified. It has also engaged extensively with industry participants and bodies in order to see whether those market features could be resolved by the OFT through actions agreed with participants within the timescale of the market study. Ultimately, while many participants agreed that there were problems in the PH market, the views among parties have proven too diverse to achieve consensus on the appropriate course of action to date. Therefore, the OFT considers that specific undertakings or orders, of the type the CC is able to agree or make, would be necessary to address any adverse effects which the CC might identify. However, as a result of its efforts to find solutions in the context of the market study, the OFT has developed a detailed understanding of the types of remedies that could be appropriate. For completeness, these are set out below.
- 10.42 **Information asymmetries:** The OFT discussed potential solutions in relation to the information asymmetries as part of the process of roundtable meetings described in more detail in Annexe B of the consultation document. They included:

- a commitment by all PH providers, building on the Hellenic Project work, to publish clear, accessible and comparable quality information within a specified timeframe
- in respect to consultants, the formulation and publication of outcome and process measures relating to treatments conducted by individual consultants – especially for routine, elective treatments – made directly available to patients GPs, PMI providers, PH providers and other relevant bodies (for example, Dr Foster) which can then be interpreted and conveyed to patients indirectly<sup>280</sup>
- the development of a choice-tool<sup>281</sup> for private patients by which self-pay prices could be better compared between rival facilities (and perhaps contrasted with PMI premium prices also)
- obligations on consultants to provide a fee estimate at or soon after first consultation in order to show an indicative price for treatment<sup>282</sup>
- as part of a fee estimate, consultants could provide information to patients on how many times in a specified time period they had requested a shortfall payment from a patient funded by PMI (across all PMI providers)<sup>283</sup>
- consultants could make their charges for a first consultation with a private patient more widely available so that patients are able to compare fees prior to attending a consultation.

<sup>280</sup> Requiring the provision of NHS outcomes data may require the CC making recommendation to Government.

<sup>281</sup> For further discussion on choice-tools, see: Office of Fair Trading, *Empowering consumers of public services through choice-tools*, April 2011 (OFT1321), page 12 in particular.

<sup>282</sup> CQC is a regulator of quality and safety under the Health and Social Care Act 2008, it has confirmed that Regulation 19 of the CQC regulations relating to fees provides for a 'statement' which must be in writing and as far as possible, is provided before the services are provided. However, CQC cannot mandate that the information is always provided before the service is received, although it suggests it should only be exceptional where it is not. The OFT has contacted the CQC during the consultation period and it has again confirmed that it cannot mandate the production of information required to address the information asymmetries.

<sup>283</sup> One of the large PH providers considered that this would not provide meaningful information to patients.

10.43 **Concentration of PH provision:** Potential remedies in this area could include:

- a recommendation to NHS and Foundation Trusts that PPU partnership arrangements should not be undertaken with a PH provider that has more than a certain share of the local market, or be subject to establishing certain conditions of access<sup>284</sup>
- obligations on PH providers in relation to access to their solus facilities.

10.44 **Reducing barriers to entry:** Potential remedies in this area could include:

- a ban on PH providers using price increases or other means to deter the recognition of new, rival facilities on the network of the PMI provider
- a ban on PH providers operating consultant incentive schemes that may disadvantage new entrants or smaller providers seeking to enter the market
- the introduction of transparency requirements for consultants such that they are required to provide details of any incentives that they receive from a PH provider to their patients, GPs and PMI providers.

10.45 The OFT does not suggest that these are the only potential remedies that might be available to the CC if it determines that one or more adverse effects on competition exist.

10.46 In conclusion, the OFT considers that there is a reasonable chance that appropriate remedies will be available to the CC in the event of a reference, should it conclude in the course of its inquiry that there are one or more adverse effects on competition.

<sup>284</sup> One PH provider sought that the OFT clarify this proposal since it felt that that the suggestion does not appear to relate to any specific concerns expressed in the consultation document and that any related assessment of harm would require a careful, case-by-case analysis of all the relevant factors. The OFT is, in this section, suggesting possible remedies only and it is ultimately for the CC to consider whether to propose any remedies should it identify any adverse effects on completion.

## Undertakings in lieu of a reference

- 10.47 The OFT has power under section 154 of the Enterprise Act 2002 to accept undertakings in lieu of a reference to the CC.
- 10.48 As noted in paragraph 10.41 above, the OFT has invested considerable focus and effort during the course of the market study in order to see whether the market features it has identified could be resolved by the OFT through actions agreed with industry participants. To date, the OFT's efforts have not led to consensus on the appropriate course of action within the timescale of the market study and the OFT has not received any offers of undertakings. Therefore, the OFT considers that specific undertakings or orders, of the type the CC is able to agree or make, would be necessary to address the problems it has identified.

## Terms of Reference

- 10.49 A number of PH providers supported the proposed Terms of Reference that that the supply and acquisition of PH services should be considered by the CC. Some of the larger PH providers considered that the reference should include the examination of a number of specific, additional issues, such as PMI market concentration, premium prices, point of sale and other issues relating to PMI/consumer agreements.
- 10.50 A number of medical associations also expressed support for a MIR but wanted the terms of reference to cover additional concerns regarding the PMI provider's methods in controlling consultant costs and in directing the patient to consultants chosen by the PMI provider.<sup>285</sup> The consultation document proposed that the OFT would make a reference to the CC for an investigation into the supply or acquisition of PH in the UK. In the OFT's view, the terms of reference proposed in the consultation documents include the role of PMI providers in the context of the acquisition of PH services. This reflects the OFT's final Scoping Paper<sup>286</sup> which set out that the market study would focus on the role of PMI in the context of the provision of PH, in particular, PMI providers' relationships with PH providers, consultants and GPs. The OFT has

<sup>286</sup> Private healthcare – final statement of scope, OFT 1295f, March 2011.

therefore decided not to change the terms of reference from that proposed in the consultation document.<sup>287</sup>

## **Conclusion**

- 10.51 In conclusion, the OFT considers that the test in section 131 of the Enterprise Act 2002 is met, that is there are reasonable grounds to suspect that there are features of the market for PH which prevent, restrict or distort competition.
- 10.52 The OFT has identified features of the market as information asymmetries, concentration and barriers to entry. It is the OFT's view that these features, either individually or in combination, restrict, prevent or distort competition.
- 10.53 For these reasons, described in paragraphs 10.5 to 10.14 above, the OFT has decided to exercise its discretion to refer this market to the CC.

<sup>287</sup> OFT notes that section 135 of the Enterprise Act 2002 provides that the CC, on further examination of the market, may consider it appropriate to ask the OFT further to extend the scope of the reference.

## **A TERMS OF REFERENCE**

- A.1 The OFT, in exercise of its powers under Sections 131 and 133 of the Enterprise Act 2002 (the Act), hereby makes a reference to the CC for an investigation into the supply or acquisition of PH in the UK.
- A.2 The OFT has reasonable grounds for suspecting that a feature or a combination of features of the market or markets for the supply or acquisition of PH prevents, restricts or distorts competition.
- A.3 For the purposes of this reference, PH means privately funded healthcare services. These are services provided to patients via private facilities/clinics including private patient units, through the services of consultants, medical and clinical professionals who work within such facilities.