

# Private healthcare market investigation

Final report



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The Competition and Markets Authority has excluded from this published version of the report information which the Inquiry Group considers should be excluded having regard to the three considerations set out in section 244 of the Enterprise Act 2002 (specified information: considerations relevant to disclosure). The omissions are indicated by [X]. Some numbers have been replaced by a range. These are shown in square brackets.

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# Summary

## The reference

1. On 4 April 2012, the Office of Fair Trading (OFT) made a market investigation reference to the Competition Commission (CC) under sections 131 and 133 of the Enterprise Act 2002 (the Act) regarding the supply or acquisition of privately-funded healthcare services in the UK.
2. Section 134(1) of the Act requires us to decide whether ‘any feature, or combination of features, of each relevant market prevents, restricts or distorts competition in connection with the supply or acquisition of any goods or services in the United Kingdom or a part of the United Kingdom’. If the CC decides that there is such a feature or combination of features, then there is an adverse effect on competition (AEC).<sup>1</sup>
3. On 1 April 2014 the remaining functions of the CC in relation to the reference were transferred to the Competition and Markets Authority (CMA), under Schedule 5 to the Enterprise and Regulatory Reform Act 2013 and the Schedule to the Enterprise and Regulatory Reform Act 2013 (Commencement No. 6, Transitional Provisions and Savings) Order 2014 (the Order). Accordingly this report is now published by the CMA in exercise of its functions under section 136(1) of the Act, read with paragraph 2 of the Schedule to the Order.
4. This report sets out our findings based on the evidence that we reviewed and the analysis we carried out during the course of the inquiry. The Inquiry Group, now acting on behalf of the CMA, is responsible for the remaining stages of the inquiry including the implementation of remedies.

## Our findings

5. Under the OFT’s terms of reference,<sup>2</sup> private healthcare 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.’ We distinguished between those privately-funded healthcare services provided by operators of private healthcare facilities<sup>3</sup> including private hospitals<sup>4</sup> and those provided by consultants or other clinicians.
6. We found the following two features in the provision of privately-funded healthcare by private hospital operators in which we included PPUs:
  - (a) high barriers to entry and expansion for private hospitals; and
  - (b) weak competitive constraints on private hospitals in many local markets including central London.

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<sup>1</sup> Section 134(2) of the Act.

<sup>2</sup> Terms of reference.

<sup>3</sup> A facility that charges for its services and treats patients on either an inpatient, day-case and/or outpatient basis. Patients that are inpatients or day-case patients will be admitted to the hospital or other facility, the distinction being merely whether the patient is expected to stay overnight (inpatient). Outpatients are not admitted.

<sup>4</sup> When we refer to private hospital operators we generally mean a person who operates a private healthcare facility that has inpatient facilities including NHS private patient units (PPUs). Similarly, by private hospital we generally mean a facility providing inpatient services as well as day-case and outpatient services.

7. We found that these features in combination gave rise to AECs in the markets for the provision of hospital services which lead to higher prices charged for inpatient and some day-case and outpatient treatments to self-pay patients at private hospitals in many local markets subject to weak competitive constraints across the UK, including central London. These features also in combination gave rise to AECs in the markets for hospital services which lead to higher prices across the range of treatments being charged by HCA<sup>5</sup> to private medical insurers (insurers) for hospital services to insured patients in central London.<sup>6</sup>
8. We found that the existence of certain benefits and incentive schemes provided by private hospital operators which reward (directly or indirectly) referring clinicians for treating patients at, or commissioning tests from, their private healthcare facilities were a feature of the provision of privately-funded healthcare services by private hospital operators. This feature gave rise to AECs in the markets for the provision of hospital services by private hospital operators across the UK due to the distortion of referral decisions to their private healthcare facilities and distorting patient choice of diagnosis and treatment options.
9. We found that the lack of sufficient publicly available performance information on private healthcare facilities was a feature of the provision of privately-funded healthcare services by operators of private healthcare facilities. This feature gave rise to AECs in the markets for the provision of hospital services in private healthcare facilities across the UK by preventing patients from exercising effective choice in selecting the private healthcare facilities at which to be treated. This reduces competition between private healthcare facilities on the basis of quality and price.
10. We found that the lack of sufficient publicly available performance and fee information on consultants was a feature in the provision of privately-funded healthcare services by consultants. This feature gives rise to AECs in the provision of private consultant services across the UK by preventing patients from exercising effective choice in selecting the consultants by whom to be diagnosed and treated. This reduces competition between consultants on the basis of quality and price.
11. Our estimate of consumer detriment arising from these AECs is set out at paragraphs 69 to 71 below. Paragraph 72 below summarizes our findings on remedies.

## Theories of harm

12. In order to provide focus and structure to our investigation, at an early stage in the investigation we identified seven theories of harm (ToHs):<sup>7</sup>
  - (a) ToH1: a private hospital operator may have market power with respect to patients in a particular geographic area.
  - (b) ToH2: individual consultants or consultant groups in some local areas may have market power over their patients.
  - (c) ToH3: a private hospital operator may have market power with respect to insurers in national negotiations.
  - (d) ToH4: an insurer may have buyer power over individual consultants.

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<sup>5</sup> HCA International Limited and any company in the group as appropriate.

<sup>6</sup> The area inside the North and South Circular Roads.

<sup>7</sup> [Issues statement](#).

- (e) ToH5: there may be barriers to entry into the supply of privately-funded health-care services.
  - (f) ToH6: there may be information asymmetries and limited information available to patients as well as general practitioners (GPs) and possibly insurers.
  - (g) ToH7: there may be vertical linkages that lead to foreclosure.
13. We reported on the progress of our investigation under each of these ToHs when we published our annotated issues statement in February 2013 and our provisional findings in August 2013.<sup>8</sup>

## **The relevant markets**

14. Privately-funded healthcare services consist of highly differentiated medical treatments that can be segmented, to a large extent, by type of care (ie inpatient, day case and outpatient) and by specialty (eg cardiology, orthopaedic). Privately-funded healthcare services are provided to patients mainly by consultants, other medical and clinical professionals, private hospitals and clinics, and NHS PPUs. These services are mainly funded by patients themselves or by insurers.
15. When defining the product market(s), we first looked at evidence on demand-side substitution by patients across different medical treatments and across privately-funded and NHS-funded medical treatments. We then considered whether, in the absence of demand-side substitutability across medical treatments, private healthcare providers have the capabilities and assets to redirect services across medical treatments (supply-side substitution). We focused this analysis of private healthcare providers on private hospitals and consultants. In addition, in relation to hospitals, we also considered whether the set of private healthcare providers and the conditions of competition were similar across medical treatments.
16. We found distinct product markets in the provision of hospital services for individual specialties and, for each specialty, separate markets for inpatient, day-patient and outpatient services. In the provision of consultant services, we considered each specialty as a separate product market.
17. In relation to hospital services, in our competitive assessment we considered constraints within these markets arising in the provision of more complex treatments (also referred to as 'high acuity' or 'tertiary' care) and constraints exerted from outside the markets by NHS hospitals.
18. As regards geographic markets for (private) healthcare, most patients have a preference to travel shorter distances, all else being equal, and to choose local consultants and hospitals to receive medical treatment. This indicated to us that the geographic scope of competition in the provision of privately funded healthcare services is local for both consultant and hospital services, and was likely to be broadly similar in the two cases. However, for the purposes of our investigation, it was not necessary to define the geographic scope of the local markets for consultant services.
19. In relation to hospital services, we considered the location of suppliers and defined local geographic markets as the areas covering sets of private hospitals and PPUs competing closely because enough patients considered them to be substitutes. For

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<sup>8</sup> [Annotated issues statement](#) and [provisional findings report](#).

hospitals located outside central London, where private hospitals are generally geographically dispersed, we identified the local geographic markets by reference to each hospital's catchment area, ie the area around the hospital from which a hospital's patients were drawn. By contrast in central London there were many hospitals in close proximity. We found that generally hospitals in central London were close substitutes for each other, but were only weakly constrained by hospitals outside central London. We therefore considered the area covering the private hospitals including PPU's in central London as a separate geographic market.

20. However, in all our local competitive assessments, we took into account the strength of the competitive constraints exerted on a private hospital by other hospitals both within and outside these markets.

### **Competitive assessment of private hospitals**

21. We focused our analysis on private hospitals including PPU's that provide inpatient care. We noted that, while providers of inpatient care compete with a wider set of providers, including day- and outpatient-only clinics, in the provision of day-patient and/or outpatient care this was unlikely to hold across the full range of day-patient and outpatient treatments. In particular, certain day-patient and outpatient treatments (for example, those which require inpatient care as a back-up or those which are ancillary to an inpatient treatment) were likely to be subject to similar competitive conditions as those arising in the provision of inpatient treatments.

### **Barriers to entry and expansion**

22. We examined the extent to which incumbent private hospitals were constrained by the threat of entry or expansion. We concluded that significant barriers to entry and expansion exist. We concluded that in all local areas including central London a combination of high sunk costs and long lead times associated with developing a private hospital together constituted significant barriers to entry and expansion.
23. In addition, we also found that in central London the lack of availability of suitable sites from which to operate a private hospital and the difficulty in obtaining planning permission for a private hospital were further significant barriers to entry and expansion.

### ***Local competitive constraints (including concentration)***

24. We assessed local competitive conditions in order to determine whether or not the competitive constraints exerted by private hospitals on each other at the local level were too low.
25. We identified those private hospitals which were unlikely to cause concern and did not require further examination. For the remaining private hospitals, we carried out local competitive assessments where we considered the available evidence, including: (a) the location of hospitals and the relative accessibility of rival hospitals (ie the degree of geographic differentiation); (b) the hospital's product offer and how this compared with nearby private hospitals and PPU's (ie the degree of product differentiation); (c) the importance to insurers of the areas in which the hospital is located; (d) documentary evidence from insurers and hospital operators; (e) the views of both hospitals and insurers; and (f) evidence of hospitals competing for PMI business at the local level.

26. As a result of the competitive assessments of individual private hospitals, we found 70 hospitals outside central London were subject to weak competitive constraints. BMI<sup>9</sup> had 37 such hospitals, Spire<sup>10</sup> 12, Nuffield<sup>11</sup> 11, Ramsay<sup>12</sup> 6 and other independent hospital operators 4.
27. We found that the competitive constraints exerted on HCA by other private hospital operators including PPUs in central London were weak. We also considered that the competitive constraints exerted by private hospitals located in Greater London and by the NHS, both inside and outside central London, were, if any, very limited. It was also our view that by virtue of its competitive position HCA has an advantage over other private hospital operators when bidding for PPU contracts and this would further strengthen HCA's position in central London. Moreover, further acquisitions of GP practices by HCA, in particular in key central London locations for insurers' corporate clients, could raise vertical competition concerns by increasing the scale of HCA's vertical relationships with such GP practices.

### **Market outcomes**

28. We looked at price outcomes, non-price outcomes and profitability.

### **Price outcomes**

29. Prices of treatments for self-pay patients were generally set locally and therefore vary across a hospital group's portfolio of hospitals. We tested statistically whether prices charged to self-pay patients were higher in areas where private hospitals faced weaker competitive constraints, using a technique known as price-concentration analysis (PCA). Our analysis showed that there was a causal relationship between local concentration and self-pay prices for inpatient treatments. Private hospital operators, on average, charged higher self-pay prices in local areas where they faced weaker competitive constraints. Our review of the qualitative evidence, which included hospital operators' views and a wide range of internal documents, indicated that the behaviour of hospital operators was consistent with this result.
30. With regard to insured patients, prices of treatments are set in national bilateral negotiations between hospital operators and insurers. Prices are generally the same for all hospitals in the hospital operator's portfolio of hospitals contracted with the insurer, thus reflecting average prices of each treatment. It is generally impossible to relate insured prices to differing local competitive conditions. This is not a problem when considering insured prices for HCA as virtually all its hospitals are located in a single geographic market, namely central London. During these negotiations, discussions typically focus on the price of the overall bundle of the hospital operator's services (ie the associated revenue), with relatively little focus on the price of individual treatments.
31. Internal documents of both hospital operators and insurers reporting the planning of negotiations showed that the competitive position of private hospitals at the local level was an important factor that both insurers and hospital operators took into consideration in their negotiations over insured prices. This was consistent with the existence of a relationship between local concentration and insured prices.

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<sup>9</sup> BMI Healthcare Limited and any company in the group as appropriate.

<sup>10</sup> Spire Healthcare Limited and any company on the group as appropriate.

<sup>11</sup> Nuffield Health and any company in the group as appropriate.

<sup>12</sup> Ramsay Health Care UK Operations Limited and any company in the group as appropriate.

32. We also found that the insurers and hospital operators were dependent upon each other and it did not appear that either side anticipated that it would survive without reaching an agreement on prices. This suggested to us that both parties to the negotiations had some degree of bargaining power, to an extent which depends on the strength of their respective outside options.
33. We conducted an empirical analysis of insured prices for inpatient and day-case treatments using a methodology which controls for a number of differences between hospital operators. Our analysis found that HCA charged significantly higher prices to insurers than The London Clinic (TLC), its closest competitor in central London, and it had significantly higher shares of supply and of capacity. We considered that our findings applied across treatments including outpatient treatments as well as inpatient and day-case. We found price differences between HCA and TLC on average across insurers, and for the large majority of insurers, for each year between 2007 and 2011. In addition, we found that most insurers paid HCA prices that were similar to and in some cases higher than the prices paid by self-pay patients on average in 2007 to 2011. Notwithstanding the limitations of our empirical analysis, we found that all the results were consistent with our hypothesis that local substitutability plays a role in determining insured prices.
34. Outside central London, in relation to BMI, Spire, Nuffield and Ramsay, our insured price analysis results were mixed. We found that:
  - (a) over the period 2007 to 2011, Ramsay, which had the least concentrated portfolio of hospitals relative to the other three operators, also received on average the lowest prices from insurers. However, BMI, which had the most concentrated portfolio, received broadly similar prices to Nuffield and Spire (which had a broadly similar concentration of hospitals of concern);
  - (b) the insurer-specific price index results, except for one insurer, were not consistent with the average price index results; and
  - (c) Some insurers generally paid prices to the four national hospital operators that were significantly lower than the prices paid by self-pay patients on average over the period 2007 to 2011, whilst other insurers generally paid prices at least as high as self-pay patients.
35. As noted at paragraph 33 above, there were a number of limitations to our empirical analysis. Notwithstanding this, overall we found that, whilst some of the results were broadly consistent with our hypothesis that local substitutability plays a role in determining insured prices, other results were not.

### *Non-price outcomes*

36. In relation to non-price outcomes, we found no evidence that quality is generally a concern in relation to privately funded healthcare. We considered that it would be extremely difficult for the CC to assess quality in relation to the provision of private hospital services as there is a lack of objectively comparable measures of quality (see further paragraphs 66 to 67 below). However, subject to this difficulty, our review of the evidence submitted found that, both within and outside central London, there was no evidence of material quality differences between private hospital operators. We also found that, notwithstanding the weak competitive constraints and barriers to entry and expansion, there is a degree of competition over both quality and range in many local areas, including central London. The evidence indicated that overall, quality and range would not worsen with greater rivalry and we had reason to believe that they would improve in more competitive markets. We expect that the



package of remedies we are putting in place (see paragraph 71 below) will improve quality and range as well as price.

### *Profitability*

37. An important indicator of the extent of competition in a market is the level of profits of the firms involved. We assessed the profitability of the seven largest private hospital operators in the UK, which account for almost 74 per cent of the market for privately-funded acute healthcare. We conducted the assessment in line with our Guidelines,<sup>13</sup> valuing assets on the basis of replacement costs.<sup>14</sup>
38. From our profitability analysis, we concluded that during the period under review BMI, HCA and Spire have been earning returns substantially and persistently in excess of the cost of capital. Ramsay has earned returns in excess of the cost of capital only in the last three years of the period and not in the first two and a half years. As a result, we did not consider that Ramsay was able to earn returns that were persistently in excess of its cost of capital. We did not find that Nuffield was earning returns substantially and persistently in excess of the cost of capital over the relevant period.

### *Conclusions on our competitive assessment of private hospitals*

39. We concluded that weak competitive constraints faced by private hospitals including PPUs in many local markets across the UK, including central London, combined with barriers to entry and expansion, lead to higher prices being charged for inpatient treatments as well as some day-case and outpatient treatments to self-pay patients in those local areas.
40. We also concluded that weak competitive constraints faced by HCA, combined with barriers to entry and expansion, lead to higher prices being charged by HCA across the range of treatments to insurers for insured patients in central London.
41. The Inquiry Group found that the features in paragraphs 39 and 40 gave rise to AECs as set out in paragraphs 6 and 7 above.
42. Three members of the Inquiry Group concluded that weak competitive constraints in the provision of hospital services by private hospitals, combined with barriers to entry and expansion, lead to higher prices being charged by BMI, Spire and Nuffield across the range of treatments to insurers for insured patients outside central London. They did not consider that this was the position in relation to Ramsay. However, the other two members of the Inquiry Group did not find that weak competitive constraints outside central London, combined with barriers to entry and expansion, were leading to higher insured prices across the range of treatments outside central London.
43. Where, as here, an Inquiry Group comprises five members, four of the members of the Inquiry Group must make the decision that a feature, or combination of features, of a relevant market prevents, restricts or distorts competition in connection with the supply or acquisition of any goods or services in the UK or a part of the UK.<sup>15</sup> Our decision, therefore, was that the weak competitive constraints combined with barriers

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<sup>13</sup> *Guidelines for market investigations*, CC3, [Annex A](#), paragraph 14.

<sup>14</sup> This approach is likely to produce different results to that shown in published accounts, particularly where businesses have been acquired at a cost that is much more than the replacement cost of the assets.

<sup>15</sup> Paragraph 20(5) of Schedule 7 to the Competition Act 1998 (as amended).

to entry and expansion that we found did not give rise to AECs in relation to insured patients outside central London.

## **Consultants**

44. We considered two theories of harm related to consultants: that individual consultants or consultant groups in some local areas may have market power over their patients and/or insurers and that an insurer may have buyer power over individual consultants which may lead to a reduction in the quality of service to patients or affect consultants' incentives to innovate.

### ***Individual consultants***

45. We found that there were factors which indicated that some individual consultants and some consultant groups in some local markets may have market power. However, we did not find that any local market power by individual consultants adversely affects competition in any local market for any specialty in the UK.

### ***Consultant groups***

46. We considered that the formation of consultant groups, as in other professions, of itself cannot be presumed to be harmful to competition. We carried out a price analysis at the local level on six anaesthetist groups which set prices and which were identified as having high local shares of supply and as being of concern to insurers. The analysis showed some evidence of price effects in one case, mixed evidence in two cases and no price effects in the other three. We decided that the results of the pricing analysis and the difficulties in obtaining data on anaesthetist groups did not justify pursuing this line of inquiry. Similarly, in relation to other consultant groups, given the limited evidence on such groups and the results of the price analysis in relation to anaesthetist groups, we did not consider that a detailed assessment of any particular consultant group in any local area would be justified.
47. We therefore did not find that the formation of anaesthetist groups or other consultant groups in general was having a widespread adverse effect on competition across many local areas. In addition, the evidence did not lead us to conclude that the formation of any individual anaesthetist group or other consultant group adversely affects competition in any local market.
48. We found that at least the two largest insurers, Bupa and AXA PPP, have significant buyer power, but we did not find sufficient evidence that it was currently being exercised in such a way as to harm competition by suppressing fees to uneconomic levels resulting in a shortage of consultants in private practice or to a reduction in innovation or quality of consultant services. Indeed, our view was that the incentive was on insurers to promote competition among consultants on price and quality and maintain innovation and quality to protect and improve demand for private medical insurance.
49. We found that some insurers, in particular Bupa and AXA PPP, were requiring some individual consultants to agree not to charge patients more than the relevant insurer's maximum reimbursement rate as a requirement to be recognized and therefore to treat the insurer's policyholders (fee-capping). On balance, the evidence we received did not demonstrate that, at present, Bupa (or indeed any other insurer) was distorting competition between consultants by imposing fee-capping, in particular on newly-recognized consultants, as a condition for recognition. There were clear benefits to policyholders in insurers promoting lower-cost consultants which should

be passed on to their policyholders in the form of lower premiums. However, there was also the risk that without transparent and fair review mechanisms and flexibility in application, uniform fees could lead to a distortion of competition between consultants and an adverse effect on quality and innovation.

50. We received many complaints about the conduct of the insurers in their dealings with consultants, a high proportion relating to Bupa. The vast majority were from consultants, but there were also approximately 40 complaints from policyholders. Trade bodies and some hospital operators supported these concerns. We considered that whilst many of the issues raised did not indicate a current competition problem in the provision of consultant services, they raised important issues. We considered that insurers, and in particular Bupa, as they increase their role in directing patients to consultants, needed to ensure that their policyholders were provided with clear and accurate information about the terms of their policies. Similarly, they needed to ensure that their interaction with consultants was fair and transparent to enable consultants to manage their practices and treat their patients effectively.

## **Clinician incentives**

51. One of the ways in which private hospitals attract business is by encouraging consultants to treat private patients at their facilities. As most patients are referred to consultants by GPs, private hospitals may also try to encourage GPs to refer patients to consultants who use their facilities. In doing so, private hospitals can be expected to take account of the General Medical Council's (GMC's) advice contained in its Good Medical Practice and associated guidance.
52. The competitive harm that potentially arises from clinician incentives was that, despite caveats relating to patients' best interests, such incentives might incline consultants to recommend treatment at a particular private facility rather than at another facility which may have equivalent or better facilities and/or which may be more competitive on price. Patients would not be aware that the clinician may have other incentives to recommend a particular facility or particular treatment or diagnostics. In these circumstances, private hospital operators may choose to compete over the value and nature of rewards that they offered to attract referrals rather than on the basis of the quality or price of their services.
53. We found that private hospital operators use a variety of benefits and schemes to encourage clinicians to treat patients at, or commission tests from, their facilities and that these were widespread. What was also relatively common was the lack of transparency in relation to such schemes. We considered whether some benefits and incentive schemes were more likely to give rise to competitive concerns than others.
54. Benefits provided to clinicians ranged from basic workplace amenities such as free tea and coffee, newspapers and stationery to higher-value benefits such as free or subsidized consulting rooms and parking spaces, payment of or contributions towards medical indemnity insurance for private work and free or subsidized secretarial services. In addition, we found formal incentive payment schemes which linked consultant performance in terms of revenue generation to cash rewards. We found that cash-based incentive schemes became much less common from around 2011, but that equity participation arrangements, which shared some of the characteristics of these incentive schemes, became more common.
55. We concluded that the value of certain benefits provided by hospital operators to referring clinicians practising at their facilities, in particular basic workplace amenities, were very low value that they would be unlikely to influence their conduct. We found that direct benefits and incentive schemes were more likely than indirect schemes to

affect competition adversely and that these are more likely to arise in the context of clinician advice on choice of private healthcare facility than choice of treatment.

56. We found that the capacity of indirect schemes to influence clinician conduct, in which we would include certain equity participation arrangements, varied with the extent to which an individual's incentives were diluted and with their value. We noted, however, that equity participation agreements were often accompanied by consultant commitments to practise at the facility concerned, in which case competition would be adversely affected, irrespective of caveats regarding the patient's best interests.

### ***Conclusion on clinician incentive schemes***

57. We found that the existence of certain benefits and incentive schemes operated by private hospital operators which reward (directly or indirectly) referring clinicians for treating patients at, or commissioning tests from, their facilities were a feature which adversely affects competition in the provision of hospital services by private hospital operators across the UK.

### **Information availability and asymmetry**

58. We considered information availability and asymmetry in three contexts: choosing a consultant, choosing a treatment option; and choosing a private healthcare facility.

#### ***Choosing a consultant***

59. We took the view that for competition between consultants to function well, patients would need to know, in addition to the consultant's fee structure, information about the consultant's qualifications, areas of expertise, extent of experience and performance.
60. We found that information on the qualifications and specialisms of consultants was readily available across the UK via private and NHS hospital websites, portals such as Dr Foster, GPs and consultants' own websites, although information on consultants' fees was more limited.
61. NHS England has recently published individual consultant performance data in ten specialisms, with plans to extend this initiative significantly over the next few years.<sup>16</sup> We understood that no equivalent programmes to disclose consultant performance information were envisaged for the rest of the UK.
62. We could not be sure when or whether the remaining consultant performance data which it is envisaged will be disclosed in England will appear, nor whether plans to disclose the same or analogous information in Scotland, Wales and Northern Ireland will emerge. Moreover, we thought that the data published by NHS England, while useful, would not represent a comprehensive solution to the current lack of performance information on consultants. In particular, we were concerned that the majority of this information focused on mortality rates, which can be very low for many of the procedures listed, making them an unreliable basis on which to distinguish between consultants. We thought that a broader range of outcome measures would be necessary to facilitate patient choice.

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<sup>16</sup> In particular, NHS England plans to include a broader range of specialties and procedures in the dataset. [www.nhs.uk/choiceintheNHS/Yourchoices/consultant-choice/Pages/consultant-data.aspx](http://www.nhs.uk/choiceintheNHS/Yourchoices/consultant-choice/Pages/consultant-data.aspx).

63. In addition, we were concerned that there was evidence to suggest that some insurers were not currently being explicit with patients regarding the basis on which they were recommending or not recommending a particular consultant. For a patient to make an informed choice, they must understand whether a recommendation is based on cost or quality.
64. We therefore concluded that a lack of sufficient independent, publicly available performance and fee information on consultants was a feature in the provision of privately funded healthcare services by consultants which adversely affected competition between consultants by preventing patients from exercising effective choice in selecting consultants.

### ***Choosing a treatment option***

65. Whilst we acknowledged that information asymmetry between consultant and patient was inevitable, we considered that, in order for competition between consultants and between consultants and alternative healthcare pathways to function well, patients should have access to information on the comparative benefits of different treatment options.
66. We found that patient information on treatment options was readily available across the UK. Our conclusion was, therefore, that a lack of patient information on treatment options was not a feature of the provision privately funded healthcare services giving rise to AECs.

### ***Choosing a private hospital***

67. Information on the performance of private healthcare facilities has been poor in the past and below the standard of the information available on NHS hospitals. During the course of our investigation a fresh initiative (the Private Healthcare Information Network (PHIN)) was launched to improve the quality of information that was available to patients.
68. Whilst this information was expected to improve in terms of healthcare facilities coverage and range of indicators, we concluded that, at present, it is insufficient to promote competition between private healthcare facilities. We therefore concluded that the lack of publicly available performance information on private healthcare facilities was a feature of the provision of privately funded healthcare services across the UK due to the distortion of competition between private healthcare facilities by preventing patients from exercising effective choice in selecting facilities at which to be treated.

### **Detriment from the AECs identified**

69. Paragraphs 6 to 10 above set out the AECs that we have found. We have estimated the consumer detriment resulting from the market power of the three largest private hospital operators (BMI, HCA and Spire) using our profitability analysis. Together these hospital operators account for 52 per cent of privately-funded healthcare services.
70. This analysis was based on the private hospital activities of the relevant firms. As NHS services are outside the scope of our reference, we have sought to exclude them from our estimate of detriment. Our estimate apportioned earnings before interest and tax (EBIT) and capital employed between NHS and private work in proportion to the revenue earned from each source. We then calculated the

difference between the return on capital employed (ROCE) and the cost of capital (taken to be 10 per cent).

71. On this basis, our estimate of the consumer detriment resulting from the three largest private hospital operators was between £155 million and £174 million per year between 2009 and 2011, which was equivalent to around 10 per cent of the total private revenues of these firms (BMI, HCA and Spire). We considered that this represented a conservative estimate of the consumer detriment.

## **Remedies**

### ***Summary***

72. To address the AECs we identified, we decided to implement a remedies package comprising four elements:
- (a) The divestiture by HCA of either the London Bridge and the Princess Grace hospitals or the Wellington hospital including the Wellington Hospital Platinum Medical Centre (PMC).
  - (b) Measures to ensure that arrangements between NHS trusts and private hospital operators to operate or manage a PPU will be capable of review by the CMA. The CMA will be able to prohibit arrangements which it decides significantly lessen competition in the relevant local area.
  - (c) A restriction or ban on certain benefits and incentive schemes provided by private hospital operators to clinicians.
  - (d) A combination of measures to improve the public availability of information on consultant fees and of information on the performance of consultants and private hospitals.

### ***Remedies not pursued***

73. We decided not to pursue the following remedies:
- (a) Divestment of any private healthcare facilities belonging to private hospital operators other than HCA.
  - (b) Constraints on contract terms between insurers and private hospital operators.
  - (c) Price controls.
  - (d) Other measures proposed by parties.

## **Divestiture**

74. Our divestiture remedy will introduce greater rivalry in central London on price, quality and range. It will require HCA to divest either the London Bridge and Princess Grace hospitals or the Wellington hospital including PMC ('the divestment package'). We considered that divestment of either elements of the divestment package will result in lower prices together with the maintenance or improvement of standards at these facilities given the importance of high-quality care in attracting and retaining corporate clients, patients and consultants.

75. HCA will be able to choose which of the alternative elements of the package to divest and will be required to confirm its choice to the CMA by a specified date. We will require that an effective divestiture process takes place which protects the competitive potential of the divestiture package before disposal and which enables a suitable purchaser or purchasers to be secured in an acceptable time frame whilst, subject to these requirements, enabling HCA to achieve a fair market value from the sale. Suitable purchasers will be independent of HCA, must not raise further competitive or regulatory concerns and must have appropriate financial resources, expertise, assets and business plans to enable the divested hospital(s) to compete effectively in the central London market.
76. We considered that it would be appropriate to adopt the following measures to ensure an effective divestiture process:
- (a) Accept undertakings from, or implement an order on, HCA which imposes a duty on HCA to maintain the divestment package in good order and not to undermine the competitive position of any of the facilities in the divestment package. In particular, we require a commitment from HCA not to encourage or induce consultants or key nursing, technical or other staff currently practising or employed at the hospitals in the divestment package to move their practise (or employment) to HCA's retained facilities.
  - (b) Require HCA to appoint a monitoring trustee, paid for by HCA but approved by and reporting to the CMA in accordance with a mandate approved by the CMA, to monitor HCA's compliance with the undertakings or order.
  - (c) Require the relevant insurers to roll over their existing contract terms with the divested hospital(s) for a period of 18 months from the date of divestiture, whilst permitting a shorter period by mutual agreement.
  - (d) Specify a sufficient but not excessive time frame for an orderly divestiture process to enable a suitable purchaser to be secured in an acceptable time frame whilst enabling HCA to achieve an appropriate fair market value from the sale.
77. If HCA has not entered into a binding agreement to sell the selected elements of the HCA divestiture package to a suitable purchaser by the end of the specified divestiture period, the CMA will have the power to appoint an independent divestiture trustee to dispose of either elements of the divestment package within a further specified period to a suitable purchaser for the best terms available in the market circumstances but without a reserve price.

### ***Review of PPU arrangements with private hospital operators***

78. This remedy will address high barriers to entry and expansion and weak competitive constraints in many local markets including in central London. There will be no obligation to notify PPU arrangements, but where the CMA has concerns about arrangements between NHS Trusts and private hospital operators to operate or manage a PPU, they will be subject to CMA review. The CMA will prohibit those arrangements which the CMA decides will significantly lessen competition in the relevant local area, or in exceptional circumstances take other steps, such as accepting undertakings, as appropriate. Such a review will potentially open up local markets by enabling alternative providers to enter or expand in areas in which incumbents face weak competitive constraints.

### ***Ban or restrictions on certain benefits and incentive schemes***

79. The aim of this remedy is to prevent distortion of competition between private hospital operators by restricting and/or making more transparent the means by which private hospital operators induce referrals by providing benefits and/or incentive schemes to referring clinicians. This remedy will:
- (a) prohibit private hospital operators from procuring clinicians to give preference to their facilities by offering inducements (and prohibit clinicians from accepting such inducements) in the form of low-value direct incentives other than: (i) services intended to ensure clinical safety; (ii) basic workplace amenities; (iii) general marketing of the facility; and (iv) corporate hospitality which is proportionate and not linked to referrals;
  - (b) require private hospital operators to disclose the types of service falling within exemptions (i) to (iii) that they provide to clinicians generally;
  - (c) require a private hospital group providing goods or services of higher value to a clinician to:
    - (i) charge the clinician the market value of the goods or services;
    - (ii) allocate the relevant goods or services without giving preference; and
    - (iii) disclose on the private hospital operator's website for the relevant facility each service and the price charged within six months of the date of the relevant order;
  - (d) prohibit any scheme operated by a private hospital operator, whether contractual or otherwise, which provides an inducement to, or creates an obligation on, a clinician to treat or refer patients for tests at any of its facilities; and
  - (e) place the following conditions on equity participations held directly or indirectly by clinicians in either private hospitals or joint ventures involving companies which own or operate a private hospital:
    - (i) clinicians must pay the full market value for the stake;
    - (ii) if the equity participation is a stake in a private facility or a joint venture in which the relevant private hospital operator also has a stake, the stake of the clinician must be limited to 5 per cent per clinician;
    - (iii) the equity stake must not be linked to any requirement on the clinician, whether express or implied, to refer patients to the relevant facility or conduct a minimum percentage of private practice at that facility or practice at that hospital for a minimum period or commit to providing a given level of use of particular equipment; and
    - (iv) any dividends or profit shares must be distributed pro rata to shareholders in accordance with their stake.
80. Any scheme which does not comply with these conditions must be amended or terminated within six months of the date of the relevant order (other than those not complying with 77(e)(i) where shares have been granted prior to the date of our final order)). The CMA will review this remedy within three years of the date of the relevant order and the CMA will monitor and enforce compliance with this remedy.



## ***Providing information***

81. These measures comprise a package that will make it easier for patients, insurers, GPs and consultants to assess a private healthcare facility or consultant's suitability in terms of quality and price. This will facilitate patient choice on the basis of quality and price thus rewarding better performing facilities and consultants and will stimulate private healthcare facilities providing inpatient and day-case services and consultants to compete for patients on the basis of the publication of performance data based on objective quality criteria.
82. Our measures will require that operators of private healthcare facilities providing inpatient and day-case services to provide patient episode data for all patients treated at their facilities to an independent information organization. The CMA will specify the nature and format of the information to be supplied to the independent information organization and to be published. Publication will be made via a website operated and maintained by the information organization in a format that permits patients to search and compare results easily. Insurers will be required to include standard wording in correspondence with customers on taking out or renewing policies informing them that they will be able to obtain quality information on consultants and hospitals from the information organization's website.
83. We propose that the CMA review the remedy by April 2019 to consider whether the information requirements have been met, whether the remedy is effective in enhancing the availability of performance information for patients and whether any adjustments or refinements are needed to the information published.
84. We will also require all operators of private healthcare facilities to require all consultants practising at their facilities, as a condition of granting practising privileges, to provide fee information to patients using standard letter templates provided by the operator. The order will require both the facility operators and consultants to comply with this requirement and implement it within six months of our final report. We will also require that, by December 2016, consultants submit and maintain up-to-date information on their fees to an independent information organization for publication via its website.

## ***Effectiveness and proportionality of remedies***

85. Each of the remedy measures that form part of our package of remedies is capable of effective implementation, monitoring and enforcement. We did not consider that any of our remedies would, in isolation, address the AECs comprehensively but that in combination will increase competition between providers of privately-funded healthcare and this increased competition will benefit patients. For example, our information remedies work together with our divestment remedy by providing patients and others involved in referral decisions with adequate information on performance and price to enable patients and others effectively to weigh price and, for example, travel time, against quality. The PPU remedy will assist in increasing the competitive constraints on incumbent private hospital operators in any local areas where an NHS Trust wishes to partner with a private hospital operator to operate a PPU. Without the remedy on clinician incentives, the other remedies might be frustrated through the use of incentives to influence clinician referrals.
86. We considered a number of alternatives but were unable to identify a less onerous package of measures that would be as effective. We concluded that the remedies package would not result in any material reduction in relevant customer benefits that might accrue from any of the features that give rise to the AECs. In relation to proportionality, we concluded that having evaluated the prospective benefits and

costs of the measures, the beneficial effects of the package of remedies are likely significantly to outweigh the costs of the measures.

87. We therefore concluded that this package of remedies represents as comprehensive a solution as is reasonable and practicable for the AECs and resulting customer detriment that we found.

# Findings

## 1. The reference and our statutory task

- 1.1. On 4 April 2012, the OFT made a market investigation reference to the CC under sections 131 and 133 of the Act regarding the supply or acquisition of privately-funded healthcare services in the UK.<sup>1</sup> This document, together with its appendices, constitutes our final report.
- 1.2. On 1 April 2014 the remaining functions of the CC in relation to the reference were transferred to the Competition and Markets Authority (CMA), under Schedule 5 to the Enterprise and Regulatory Reform Act 2013 and the Schedule to the Enterprise and Regulatory Reform Act 2013 (Commencement No. 6, Transitional Provisions and Savings) Order 2014 (the Order). Accordingly this report is now published by the CMA in exercise of its functions under section 136(1) of the Enterprise Act 2002, read with paragraph 2 of the Schedule to the Order.
- 1.3. This report sets out our findings based on the evidence that we reviewed and the analysis we carried out during the course of the inquiry. The inquiry group, now acting on behalf of the CMA, is responsible for the remaining stages of the inquiry including the implementation of remedies.
- 1.4. Section 134(1) of the Act requires us to decide whether ‘any feature, or combination of features, of each relevant market prevents, restricts or distorts competition in connection with the supply or acquisition of any goods or services in the United Kingdom or a part of the United Kingdom’. If the CC decides that there is such a feature or combination of features, then there is an AEC.<sup>2</sup>
- 1.5. Under section 131(2) of the 2002 Act, a ‘feature’ of the market refers to:
  - (a) the structure of the market concerned or any aspect of that structure;
  - (b) 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
  - (c) any conduct relating to the market concerned of customers of any person who supplies or acquires goods or services.
- 1.6. If the CC finds that there is an AEC, it is required under section 134(4) of the Act to decide whether action should be taken by it, or whether it should recommend the taking of action by others, for the purpose of remedying, mitigating or preventing the AEC, or any detrimental effect on customers<sup>3</sup> so far as it has resulted from, or may be expected to result from, the AEC; and, if so, what action should be taken and what is to be remedied, mitigated or prevented. The Act requires the CC ‘to achieve as comprehensive a solution as is reasonable and practicable to the AEC and any detrimental effects on customers so far resulting from the AEC’.<sup>4</sup> In considering

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<sup>1</sup> The terms of reference for our investigation are set out in Appendix 1.1.

<sup>2</sup> [Section 134\(2\)](#) of the Act.

<sup>3</sup> A detrimental effect on customers is defined in [section 134\(5\)](#) of the Act as one taking the form of: (a) higher prices, lower quality or less choice of goods or services in any market in the UK (whether or not the market to which the feature or features concerned relate); or (b) less innovation in relation to such goods or services.

<sup>4</sup> [Section 134\(6\)](#) of the Act.

remedies, the CC may take into account any relevant consumer benefits, as defined in the Act, arising from the feature or features of the market.<sup>5</sup>

- 1.7. Our terms of reference (see Appendix 1.1) state that for the purpose of the reference, privately-funded healthcare services are services provided to patients via private facilities/clinics including private patient units (PPUs), through the services of consultants, medical and clinical professionals who work within those facilities.
- 1.8. This section provides the background to the reference; an overview of the conduct of the investigation, and the structure of the remainder of the report.

## ***Background to the reference***

### ***The OFT's reference decision***

- 1.9. The OFT commenced a market study of privately-funded healthcare in March 2011. The OFT published a consultation document on a proposal to refer the market in December 2011. Following that consultation, it decided to refer the market to the CC, having identified a number of features. These features appeared to result in reduced patient choice in privately-funded healthcare services and restricted competition between private healthcare providers, the expected outcome of which might be higher prices and lower quality of services for patients, and a stifling of innovation in the privately-funded healthcare market.
- 1.10. The OFT identified the following features which might adversely affect competition:<sup>6</sup>
  - information asymmetries resulting from a shortage of accessible, standardized and comparable information provided to patients and their advisers in relation to private healthcare providers;
  - concentration in the provision of privately-funded healthcare at the national level and at the local level areas of extreme concentration;
  - concentration of anaesthetists as a result of the prevalence of anaesthetists who are part of groups; and
  - barriers to entry as a result of conditions imposed by larger hospital operators as part of recognition of their facilities on PMI networks, the need for wide PMI network recognition and the consultant drag effect, incentives paid by hospital operators to consultants and possibly financial incentives paid by hospital operators to GPs.
- 1.11. The OFT also made two recommendations to other organizations to address two issues that arose during the course of its market study. First, responding to concerns by consumers as to the level of extra payments sought from some consultants that are not covered under their PMI (shortfalls), the OFT engaged with the Financial Services Authority (FSA) now the Financial Conduct Authority (FCA) on this issue. The CC understands that the Association of British Insurers (ABI) has confirmed to the FSA, on behalf of its members, that PMI providers will either cover the total costs 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 at point of sale and claim. Secondly, having noted the development of partnership arrange-

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<sup>5</sup> Section 134(7) of the Act.

<sup>6</sup> [http://www.of.gov.uk/shared\\_of/market-studies/OFT1412.pdf](http://www.of.gov.uk/shared_of/market-studies/OFT1412.pdf).

ments between PPUs and hospital operators, the OFT made a recommendation to the NHS and foundation trusts that when seeking to agree partnership arrangements, they should consider that the PPUs may be at a potential competitive advantage in the privately-funded healthcare market due to any implicit, non-market benefits they could receive from their connections to the NHS.

### ***Conduct of the investigation***

- 1.12. The following paragraphs provide an overview of the process we followed in our investigation and how we analysed the evidence, data and information we received. Further details can be found in Appendix 1.1.
- 1.13. We published an issues statement on 22 June 2012 taking into account the OFT's market study report and the initial information and evidence we had received in response to our initial requests for information and submissions. The issues statement identified seven hypotheses or ToHs to help frame the conduct of the investigation. In the issues statement we recognized that the industry involves a variety of suppliers and acquirers of services within the reference market including hospital operators, consultants, GPs, other medical and clinical professionals, the NHS and PMIs. However, whilst we would be investigating the various facets of the industry, including how the conduct of PMIs affects the provision of privately-funded healthcare, we did not investigate how competition functions in the PMI market, as this market was not referred by the OFT for investigation.<sup>7</sup> Similarly, healthcare services funded by the NHS, whether carried out in the NHS or privately-operated facilities, were also outside our terms of reference.<sup>8</sup>
- 1.14. We also identified at an early stage of the investigation that the role of pharmaceutical companies and equipment suppliers would not form part of the investigation.<sup>9</sup> In preparing our extensive questionnaires to parties, we decided to focus the investigation on privately-funded acute healthcare services provided primarily in private hospitals, as these were the focus of the OFT's market study and of submissions received from parties in the earlier phases of the investigation. We also decided not to consider in detail privately-funded healthcare services that are offered by different providers to those that provide private hospital-based acute services where the nature of demand is different and where such services are not covered by insurance. The following treatments were not analysed in detail as a result:
  - Elective cosmetic surgery: meaning those treatments done purely electively, including minor laser eye and skin treatments, although cosmetic procedures following trauma were included.
  - Standard maternity treatments: meaning maternity-only services by specialist providers, although in some parts of our analyses we included emergency/non-routine acute private hospital maternity treatments.
  - Fertility and pregnancy termination treatments.
  - Mental health treatments.
  - Dentistry unless provided within an acute private hospital facility.

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<sup>7</sup> [Issues statement](#), paragraph 3.

<sup>8</sup> *ibid*, paragraph 3.

<sup>9</sup> *ibid*, footnote 7.

- Specialist outpatient services such as physiotherapy and nutrition.<sup>10</sup>
- 1.15. We held 11 site visits, seven to private hospitals and four to the premises of PMIs. Between February and April 2013, we held 17 hearings with interested parties. We have had extensive contact with and/or received submissions from a large number of interested parties including hospital operators, consultants, GPs, trade and professional organizations, government departments, agencies and regulators, PMIs, PMI policyholders and patients.
  - 1.16. On 28 February 2013, we published an annotated issues statement which set out our thinking based on the evidence received and the analyses we had undertaken by that time. The statement highlighted those issues which we considered would be the focus of the investigation going forward and those issues which were of lesser concern. The annotated issues statement contained a number of working papers as appendices and we published further working papers between February and June 2013.
  - 1.17. We notified our provisional findings on 28 August and published our report in full on 2 September. We also published our Notice of possible remedies on 28 August. A number of submissions commenting on both reports were received and further hearings were also held with 11 parties to gain a greater understanding of their views.
  - 1.18. On 16 January 2014 we published the summary of our provisional decision on remedies. The full report was published on 21 January 2014. We held four further hearings with parties following publication of our provisional decision on remedies.
  - 1.19. During our investigation we published a considerable number of documents on the CC website. These include non-confidential versions of parties' written submissions, non-confidential versions of summaries of hearings held with a number of parties, parties responses to our issues statement, annotated issues statement, working papers, provisional findings and provisional decision on remedies. Further details can be found in Appendix 1.1.

### ***Structure of the final report***

- 1.20. This document, together with its appendices, constitutes our final report which sets out our findings based on our analysis of the evidence received during the course of the investigation. It refers, where appropriate, to material published separately on the CC website. The report, however, is self-contained and is designed to provide all material necessary for an understanding of our findings.
- 1.21. The remainder of this report is set out as follows:
  - Section 2 describes the background to the industry including relevant policy frameworks and regulation of the industry.
  - Section 3 provides information on the main hospital operators, on clinicians and PMI companies active in the provision of privately-funded healthcare.
  - Section 4 sets out the framework for our competitive assessment.
  - Section 5 considers market definition.

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<sup>10</sup> [Annotated issues statement](#), paragraph 4.

- Section 6 contains our analysis and assessment of competition in the supply of privately-funded healthcare by hospital operators.
  - Section 7 contains our analysis and assessment of competition in the supply of privately-funded healthcare by consultants.
  - Section 8 sets out our analysis and assessment of the issues relating to certain arrangements between hospital operators and clinicians.
  - Section 9 sets out our analysis and assessment of the issues relating to the availability of information and information asymmetries.
  - Section 10 presents our findings in relation to the statutory questions that we are required to answer.
  - Section 11 sets out the remedy measures we have decided to take forward.
  - Section 12 sets out the remedy measures we have decided against taking forward.
  - Section 13 contains our assessment of the effectiveness and proportionality of, and our conclusions on, the package of remedies.
- 1.22. Appendices supporting each section are numbered according to the first section where they are relevant and are listed in full in the table of contents at the beginning of this report.

## **2. Industry background**

### ***Introduction***

- 2.1 In this section, we summarize the nature of privately-funded healthcare, outline industry trends, explain how privately-funded healthcare services are provided and consumed, and describe the regulatory regime for this industry.
- 2.2 We begin with a high-level overview of private healthcare provision in the UK, including some of the main trends that have emerged.

### ***The nature of private healthcare***

#### ***Background***

- 2.3 Privately-funded healthcare services comprise a variety of medical treatments that are paid for directly by individuals or through PMIs.<sup>11</sup> For the purposes of this investigation, such services have been defined as services provided to patients by private hospitals and other facilities, including PPU's, through the services of consultants, and medical and clinical professionals who work within these facilities.<sup>12</sup>
- 2.4 Of the estimated 548 hospitals operating in the private healthcare sector in the UK as at October 2013, 465 were owned and managed by private companies (led by the main hospital groups), and 83 were dedicated PPU's<sup>13</sup> within NHS hospitals<sup>14</sup> (of which 74 are managed in-house by the NHS and nine are managed by private hospital groups).<sup>15</sup> In addition, there are between 500 and 600 medical clinics which are not registered as hospitals but which carry out some private healthcare treatments alongside their core general medical services.<sup>16</sup>

#### ***Private hospitals***

- 2.5 Private hospitals typically provide a broad range of healthcare services to patients, covering the majority of medical specialties.<sup>17</sup> Some private hospitals also provide a full range of oncology treatment.
- 2.6 There are a number of differences between the range of services provided by private hospitals in the UK as compared with the NHS, including:
- (a) private hospitals generally do not offer accident and emergency (or trauma) services which are, in any case, not generally covered by PMI policies, but rather focus on elective/planned treatments, both medical and surgical;
  - (b) many private hospitals do not have intensive care or high dependency units, though, as we show later, some hospital groups have focused on procedures which require level 3 intensive care facilities; and

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<sup>11</sup> They may also be paid for by overseas self-payers or by patients funded by third parties such as embassies.

<sup>12</sup> OFT Private Healthcare Market Study, 2.14, [www.of.gov.uk/shared\\_of/market-studies/OFT1412.pdf](http://www.of.gov.uk/shared_of/market-studies/OFT1412.pdf).

<sup>13</sup> In this report, we refer to all facilities within NHS hospitals for privately-funded patients as PPU's.

<sup>14</sup> Laing & Buisson, Private Acute Medical Care 2013, pp 9 & 10.

<sup>15</sup> *ibid* p 98.

<sup>16</sup> *ibid* p10.

<sup>17</sup> See paragraph 3.67.



- (c) private hospitals offer a range of treatments that may not generally be funded by the NHS or which may entail a long wait for treatment, including cosmetic and bariatric surgery and IVF treatments.

### *Clinicians*

- 2.7 As at 31 December 2012, there were 252,553 registered and licensed doctors across England, Scotland, Wales and Northern Ireland.<sup>18</sup> The majority of consultants providing privately-funded healthcare services also hold an NHS contract—very few practise exclusively in the private sector. Both the number of consultants and the number of GPs has been increasing over at least the last decade, with the number of GPs growing by about 25 per cent and the number of consultants growing by about 52 per cent since 2001.<sup>19</sup>

### ***Trends in private healthcare***

#### *Trends in the NHS*

- 2.8 The overwhelming majority of hospital admissions in the UK are to NHS hospitals. In 2012/13, there were around 8.77 million waiting list and planned admissions for surgery to NHS hospitals in the UK. This compares with an estimated 1.61 million privately-funded admissions for surgical procedures in UK private hospitals at mid-2013.<sup>20</sup>
- 2.9 Over the last decade, major changes have taken place in the NHS. Improvements in the fabric of NHS hospitals and, in particular, reductions in the length of waiting lists for surgery in the mid-2000s increased the degree of competitive tension between private healthcare and its free rival, and this was further reinforced by the economic downturn in 2008.
- 2.10 In England, the Darzi reforms<sup>21</sup> have sought to provide patients and the public with more information and greater choice, including the possibility of being treated as an NHS patient at a private hospital.<sup>22</sup> The NHS was funding the treatment of NHS patients at private hospitals prior to these reforms, but growth in NHS spending with private hospitals has been such that the NHS is now a customer of the private acute healthcare sector with a budget equivalent in size to that of some major PMIs.
- 2.11 There are differences in policy across the nations regarding the use of private facilities for treating NHS patients. In Scotland, there is no longer any central procurement of private hospital services, although NHS authorities can still procure private services locally on an ad hoc basis to meet their waiting time targets or in cases where local services become unavailable for a period. Current Scottish policy is that all healthcare spending should first be channelled through the NHS, with the aim of improving quality and where the use of the private sector is marginal. Similarly in Wales, commissioning of private providers to carry out NHS work is very low and NHS Wales' intention is that it continues to decrease. Only in exceptional cases, primarily in the sphere of mental health and access/waiting time targets, would the NHS Local Health Boards commission private providers to provide NHS healthcare.

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<sup>18</sup> GMC, *The State of Medical Education and Practice in the UK 2013*, p17.

<sup>19</sup> *ibid*, p27.

<sup>20</sup> Laing & Buisson, *Private Acute Medical Care 2013*, p123.

<sup>21</sup> Department of Health, *High Quality Care for All*, 2008.

<sup>22</sup> Since April 2009, patients have had the legal right to be referred to a [hospital of their choice](#) provided it meets NHS cost and quality requirements.

## Trends in spending

- 2.12 In 2012, the UK market for privately-funded healthcare services was worth an estimated £6.71 billion.<sup>23</sup> In real terms, the market has been flat since 2005 (up only 0.6 per cent in real terms between 2006 and 2012 inclusive).<sup>24</sup> However, private hospitals and clinics have seen their revenues increase as a result of wider use of private sector capacity by the NHS.<sup>25</sup>
- 2.13 Total revenue earned by private hospitals in the UK was approximately £4.4 billion in 2012, 70 per cent of which was generated by the five largest private hospital groups (see Table 2.1).

TABLE 2.1 Top ten private hospital operators by acute medical/surgical revenue, 2005 to 2012

Provider and range	2006 £m	2007 £m	2008 £m	2009 £m	2010 £m	2011 £m	2012 £m	2012 share %
1. General Healthcare Group	644.0	665.1	746.2	807.4	836.2	885.5	877.5	20.0
Netcare Healthcare UK	23.0	23.8	26.4	24.1	19.0	2.2	1.0	0.0
2. Spire Healthcare	420.6	449.3	564.1	620.0	643.0	674.0	739.0	16.9
3. HCA	331.3	368.2	419.7	448.0	490.3	585.9	662.0	15.1
4. Nuffield Health	448.5	455.4	420.2	389.2	391.6	414.2	450.6	10.3
5. Ramsay Health Care UK	227.7	251.9	273.7	322.2	351.4	357.7	363.8	8.3
Top five providers	2,095	2,214	2,450	2,611	2,732	2,920	3,094	70.6
6. Care UK	32.4	42.3	121.1	137.9	148.3	150.0	145.0	3.3
Partnership Health Group	32.0	54.4	-	-	-	-	-	-
7. The London Clinic	75.0	81.3	94.1	102.5	114.7	124.3	131.1	3.0
8. Aspen	52.1	59.0	65.8	67.2	66.4	68.7	89.0	2.0
9. Bupa's Cromwell Hospital	65.5	61.9	63.6	64.7	67.3	73.0	83.2	1.9
10. Circle	13.4	24.2	35.0	63.1	76.2	74.6	73.2	1.7
Top ten providers	2,365	2,537	2,830	3,046	3,205	3,411	3,616	82.5
Other providers	604.6	669.9	672.4	692.6	717.1	745.4	769.6	17.5
All private hospital operators	2,970	3,207	3,502	3,739	3,922	4,156	4,385	100.0

Source: Laing and Buisson Private Acute Medical Care, 2013, p46.

- 2.14 Since 2004, when it began using the private sector to clear waiting lists, NHS England's spending on privately-funded healthcare services has more than quadrupled in real terms and, in 2012, its spend was £1.195 billion.<sup>26</sup> In 2011/12, nearly 20 per cent of NHS expenditure on hip and knee replacements was with private hospitals and clinics.<sup>27</sup> As we show when we describe private healthcare provision in more detail, most hospital groups, but Ramsay in particular, have benefited from the growth of NHS expenditure on private treatment.<sup>28</sup>
- 2.15 Not all private hospitals have seen winning higher-volume, lower-acuity NHS work as a key part of their business strategy. While representing a threat to private hospitals in one respect, the increasing cost and sophistication of medical technology used to diagnose, monitor and treat patients has been identified as a major opportunity by certain hospital groups. They have chosen to develop a strategy focused on high-value, high-acuity medical specialties, which require heavy expenditure to enter and expand into. Our case study on The London Clinic's (TLC's) Cancer Centre (see

<sup>23</sup> Laing & Buisson, Private Acute Medical Care 2013, pi.

<sup>24</sup> *ibid* pi.

<sup>25</sup> *ibid* pi

<sup>26</sup> *ibid*, p19.

<sup>27</sup> [Public Payment and Private Provision](#), Nuffield Trust and Institute for Fiscal Studies, 2013. However, the authors suggest that this may include some patient substitution from the private sector to the NHS.

<sup>28</sup> See paragraph 3.33.

Appendix 6.2) illustrates the willingness of some providers, particularly TLC and HCA, to make very significant investments in equipment and facilities to try and secure an increased share of certain segments of the healthcare market, particularly oncology.

### *Trends in delivery*

- 2.16 Trends relevant to the delivery of privately-funded healthcare services include a declining proportion of patients being admitted to private hospitals as inpatients and shorter hospital stays for those that are.
- 2.17 NHS hospitals have sought to reduce costs by treating more patients on a day-patient basis and, where they are admitted as inpatients, reducing their length of stay. The average length of stay in NHS hospitals has fallen by a third in the last ten years<sup>29</sup> through the adoption of, for example, less invasive surgical techniques for which recovery periods are shorter, and the adoption of procedures that can be undertaken on a day-patient basis. The number of day-patient-only beds in the NHS almost doubled between 2002/03 and 2012/13,<sup>30</sup> and figures available (for April 2013) indicate that just over 80 per cent of NHS elective admissions in England are on a day-patient basis.<sup>31</sup> Outpatient treatments have also increased across the UK, though this has occurred more noticeably in England than in Scotland, Wales or Northern Ireland.<sup>32</sup>
- 2.18 The trend is similar in the private healthcare sector but less pronounced. Between the mid-1990s and mid-2000s overnight bed capacity in the sector gradually contracted by around a fifth to a low of 9,250 at 2004.<sup>33</sup> In 2012/13, overnight bed capacity remained largely static on previous years, with 9,341 beds available at the 201 private hospitals offering overnight beds.<sup>34</sup> Day-patient admissions by the main hospital groups represented 68 per cent of all admissions in 2011 (see Figure 2.1), and the majority (73 per cent) of the 1.61 million patient admissions for surgical procedures in the first half of 2013 were for day-patient procedures.<sup>35</sup>

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<sup>29</sup> Length of stay in hospital in England, Nuffield Trust.

<sup>30</sup> [www.nuffieldtrust.org.uk/data-and-charts/day-only-hospital-beds-england](http://www.nuffieldtrust.org.uk/data-and-charts/day-only-hospital-beds-england).

<sup>31</sup> [www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/MAR-April-13-SPN-v2-89036.pdf](http://www.england.nhs.uk/statistics/wp-content/uploads/sites/2/2013/04/MAR-April-13-SPN-v2-89036.pdf).

<sup>32</sup> [www.nuffieldtrust.org.uk/data-and-charts/outpatient-appointments-uk](http://www.nuffieldtrust.org.uk/data-and-charts/outpatient-appointments-uk).

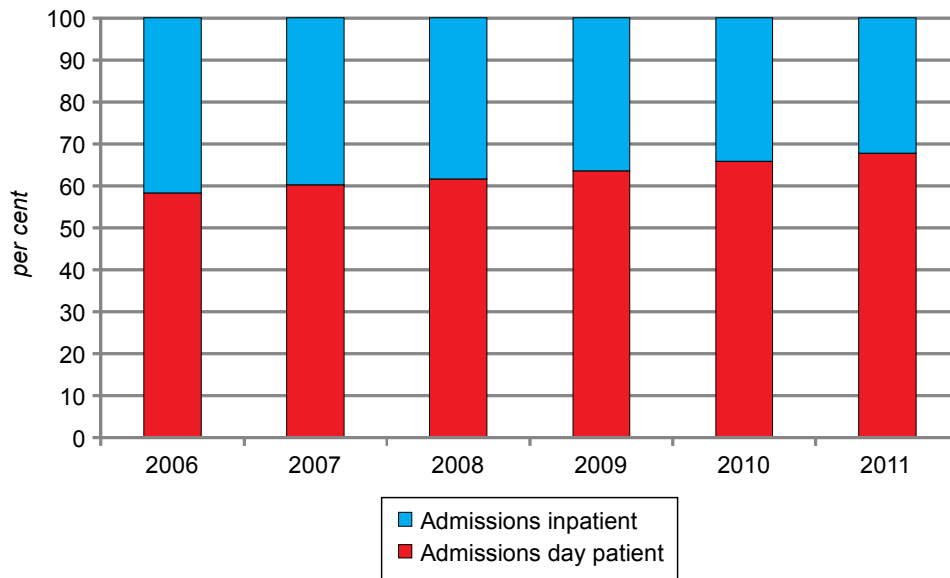
<sup>33</sup> Laing & Buisson Private Acute Medical Care 2013, p119.

<sup>34</sup> *ibid* pii.

<sup>35</sup> *ibid* p10.

FIGURE 2.1

**Day-patient and inpatient admissions at the major hospital groups,  
2006 to 2011**



Source: BMI, HCA, Nuffield, Ramsay, Spire.

***Spending in private healthcare***

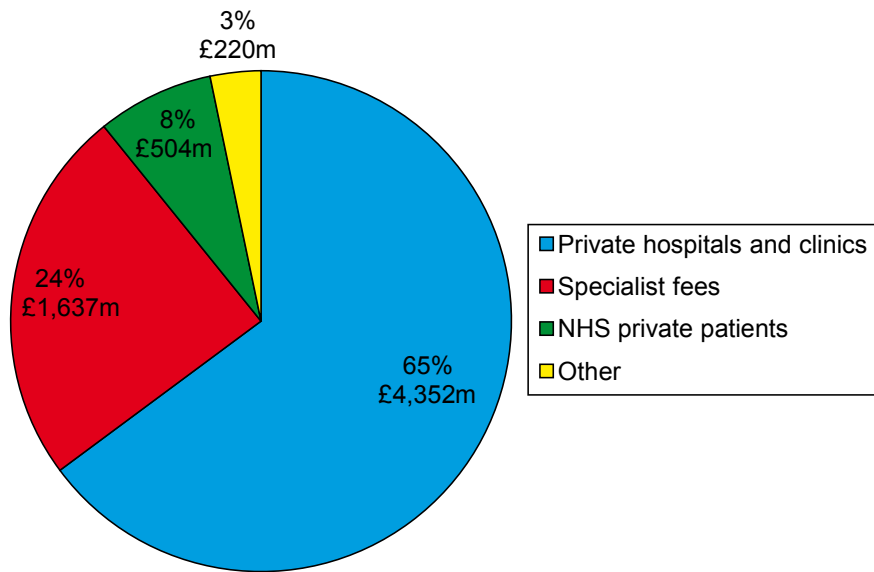
2.19 We now look at where the money is being spent on privately-funded healthcare services, and by whom.

***Expenditure on privately-funded healthcare services***

2.20 Roughly two-thirds of expenditure on privately-funded healthcare services is on private hospitals. The next largest category of expenditure is specialists' fees and the third largest is the NHS (money spent treating private patients at NHS facilities such as PPUs). The breakdown of expenditure by segment is shown in Figure 2.2.

FIGURE 2.2

**Private healthcare—revenue and share by sector, 2012**

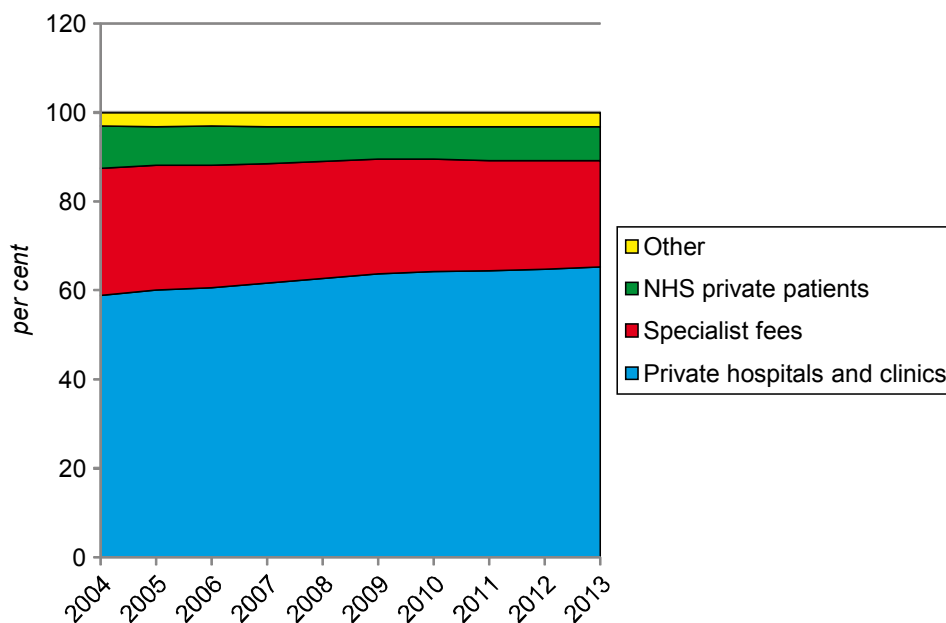


Source: Laing & Buisson, Private Acute Medical Care 2013, p3.

- 2.21 Since 2004, the share of private healthcare revenue earned by the NHS through private beds and PPUs has fallen slightly, while the share earned by hospitals and consultants has increased (see Figure 2.3).

FIGURE 2.3

**Trends in private healthcare revenue shares, 2004 to 2013**

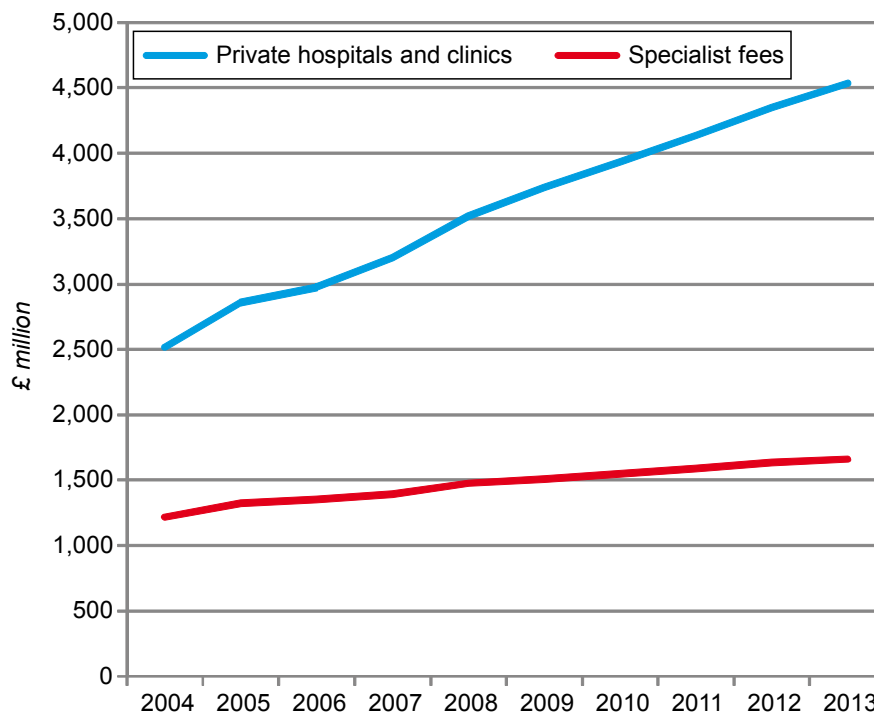


Source: Laing & Buisson, Private Acute Medical Care 2013, p4. Note that 2013 figures represent a projected value.

- 2.22 Revenue earned from private hospital charges grew much more rapidly than revenue from consultants' fees (see Figure 2.4).

FIGURE 2.4

### Hospital revenue and specialist fees, 2004 to 2013



Source: Laing & Buisson, *Private Acute Medical Care* 2013, p4. Note that 2013 figures represent a projected value.

- 2.23 This was despite the low growth of private expenditure on healthcare and the reduction in episode costs that might have been expected to flow from the increase in the proportion of day-patient, rather than inpatient, admissions to private hospitals.

### *NHS expenditure on privately-funded healthcare services*

- 2.24 As noted above in paragraph 2.12, private hospital revenues were being driven to a greater or lesser extent, depending on the operator, by increased volumes of NHS work and in other cases, as discussed in paragraph 2.15, by hospitals focusing on high-acuity treatments.
- 2.25 In the 2012/13 financial year, NHS England generated approximately £500 million in revenue from the provision of privately-funded healthcare services (contributing 8 per cent of total private healthcare industry revenue), either in dedicated PPUs or in private beds in NHS hospitals.<sup>36</sup> Around 96 per cent of total UK NHS private patient revenues are generated in England while 1.6 per cent of revenues are generated in Wales, 1.2 per cent in Northern Ireland and 0.9 per cent in Scotland.<sup>37</sup> The majority of PPU capacity is located in London and south-east England.<sup>38</sup> Again, the differences in the nations may be explained, in part, by the different policies in place: in Wales, for example, there are very few PPUs, and while it is recognized that for some procedures there is scope for the local health boards to offer these on a private

<sup>36</sup> Laing & Buisson, *Private Acute Medical Care* 2013, p93.

<sup>37</sup> *ibid* p96.

<sup>38</sup> Around 53 per cent of PPU beds are in London and 10 per cent in the southern Home Counties (Laing & Buisson *Private Acute Medical Care* 2013, p96).

basis, it is critical that such private provision does not impact negatively on NHS provision.

2.26 The top ten NHS Trusts by private patient revenue are shown in Table 2.2.

TABLE 2.2 Top ten private patient earning NHS Trusts in 2012/13 and 2011/12

	<i>Private patient revenue 2012/13 £m</i>	<i>Private patient revenue 2011/12 £m</i>	<i>Annual growth 2011/12–2012/13 %</i>	<i>Share of total NHS private patient revenue 2012/13 %</i>
1. Royal Marsden FT	59.8	51.1	17.0	11.9
2. Great Ormond Street FT	41.3	28.2	46.7	8.2
3. Imperial College Healthcare	30.5	28.6	6.6	6.0
4. Royal Brompton & Harefield FT	28.8	29.1	–1.1	5.7
5. Royal Free Hampstead	21.8	21.2	2.5	4.3
6. Moorfields Eye Hospital FT	19.2	19.2	0.0	3.8
7. University College London FT	18.3	13.4	37.0	3.6
8. Guys & St Thomas' FT	17.7	21.2	–16.8	3.5
9. Kings College Hospital FT	13.2	10.7	22.8	2.6
10. Chelsea & Westminster FT	10.9	10.5	4.5	2.2
Top 10 Trusts	261.5	233.2	12.1	51.8
Other Trusts	242.9	248.9	–7.5	48.2
Total NHS (UK)	504.4	482.1	4.6	100.0

Source: Laing & Buisson, Private Acute Medical Care 2013, p97.

2.27 As can be seen, the average rate of revenue growth among the top ten PPUs is high (12.1 per cent). Some individual PPUs are achieving growth rates significantly higher than this, for example, Great Ormond Street has experienced growth around three times the top-ten average. It is also notable that the top ten PPUs comprised 51.8 per cent of the total private patient revenue earned by the NHS in 2012/13, while all other PPUs combined made up 48.2 per cent.

2.28 Of the 83 dedicated PPUs in the UK, 74 are managed in-house by the NHS and nine are managed by private hospital groups. HCA manages the Harley Street at University College Hospital, London, the Harley Street at Queens, Romford, The Christie Clinic in Manchester; BMI operates the Coombe Wing at Kingston Hospital; Spire manages the Royal Orthopaedic Hospital Trust's PPU at Stanmore; Ramsay manages the Orwell Cardiothoracic PPU at Basildon University Hospital; Nova Healthcare runs a PPU at St James' Institute of Oncology in Leeds; Regents Park Heart Clinics operates the Cambridge Heart Clinic at Addenbrooke Hospital and Mater Private started managing a new private centre in Wirral in 2013 as part of a joint venture (JV) with the Clatterbridge Cancer Centre NHS Foundation Trust. In addition, East Kent Medical Services—recently reacquired by East Kent Hospitals University NHS Foundation Trust—manages the Spencer Wings at Ashford and Margate,<sup>39</sup> and HCA will operate and manage a new PPU at Guy's and St Thomas'.

2.29 Industry observers expect PPU revenue to grow in the next three to five years, now that the limit on the proportion of Foundation Trusts' gross income that can be earned from private healthcare has been raised to 49 per cent, though it is not anticipated that any Foundation Trust will reach this level of private patient income.<sup>40</sup> There is evidence that the leading PPUs, for example the Royal Marsden, Great Ormond Street, Moorfields Eye Hospital and Chelsea and Westminster NHS Foundation Trust, are gearing up for growth.<sup>41</sup> However, the degree to which any increase in PPU activity will constitute greater competition for private hospitals will be affected by

<sup>39</sup> Laing & Buisson, Private Acute Medical Care 2013, p98.

<sup>40</sup> *ibid* p104.

<sup>41</sup> *ibid* p105.

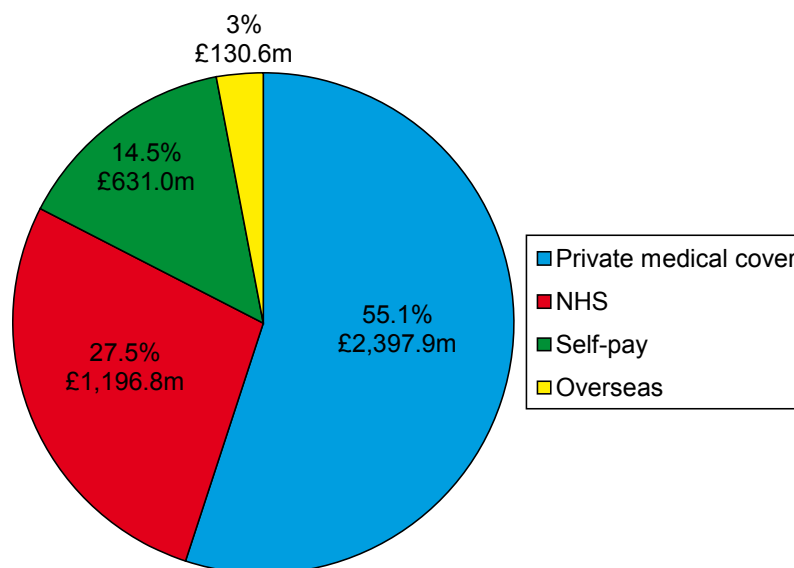
the number of Foundation Trusts which decide to expand in partnership with private hospitals, if and with whom they partner, and on what terms, among other things.

### *Purchasers of private healthcare*

- 2.30 Private hospitals have four main revenue sources: overseas patients, self-pay patients, NHS-funded patients and, by far the largest category, patients with PMI. We set out the value of these in Figure 2.5 and discuss each in turn.

FIGURE 2.5

### **Sources of funding of private acute healthcare at private hospitals, 2012**



Source: Laing & Buisson, Private Acute Medical Care, 2013, p13.

- 2.31 The relative dependence of the main hospital groups on each of these sources varies—see Figure 2.6.

FIGURE 2.6

### **Hospital groups' revenue sources, 2012**

[✂]

Source: Parties and CC analysis.

### *Overseas*

- 2.32 The overseas sector comprises overseas residents who come to the UK, in particular to central London, for medical treatment. This would include what is sometimes referred to as the 'embassy' sector, since the London embassy of the country concerned may be responsible for negotiating rates with hospitals, arranging treatment, and paying the fees involved. The size of this market segment was estimated at



£128 million in 2012,<sup>42</sup> though information submitted by the parties suggested that it may be worth somewhat more than this.

### *Self-pay*

- 2.33 In 2012, the self-pay market was worth £629 million to private hospitals, and comprised non-cosmetic (£420 million) and cosmetic treatments (£209 million). In 2013, the value of the self-pay sector is expected to reach £650 million.<sup>43</sup>
- 2.34 The most significant drivers of the self-pay market appear to be the economic cycle/GDP growth, though industry commentators have pointed to a growth in self-pay demand from 2008 when the economy was contracting. This may have been related to increased NHS waiting times, but also may have resulted from increased marketing of self-pay by hospital groups.<sup>44</sup>

### *The NHS*

- 2.35 The second largest customer of private hospitals and the fastest-growing source of revenue for private healthcare services in the last ten years has been the NHS. As described in paragraph 2.14, the NHS's spending with private hospitals has more than quadrupled in real terms since 2004. Just over a quarter of private hospitals' revenue, on average, comes from the NHS<sup>45</sup> which is, therefore, a significant additional revenue source as well as, to a much lesser extent, a competitor of the private hospital operators. As noted earlier, the growth of NHS revenue has, to some extent at least, sheltered private hospitals from the weak state of the privately paid for healthcare sector.
- 2.36 However, the amount of NHS work that hospital groups and individual hospitals undertake varies quite considerably. HCA, for example, earns very little from treating NHS patients, whereas almost [§] of Ramsay's admissions were NHS patients in 2010/11. Ramsay accounted for 27.6 per cent of NHS-funded elective surgery admissions to private hospitals in 2011/12.<sup>46</sup> There is also geographic variation, as explained in paragraph 2.11; the extent to which the NHS will fund the treatment of NHS patients in private hospitals is much more common in England than in Scotland or Wales, for example.

### *PMI*

- 2.37 Payments from PMIs account for the largest source of funding for private hospitals, generating an estimated £2,397.9 million or 55.1 per cent of revenues in 2012<sup>47</sup> (see Figure 2.5). However, while there was positive real growth in 2008 and 2009, recessionary effects resulted in a contraction in payouts of about 0.4 per cent in 2012, following contractions of 3.1 per cent in 2011 and 2.8 per cent in 2010.<sup>48</sup>
- 2.38 The future of PMI spending on privately-funded healthcare services appears mixed. There has been some improved demand for cover by employers in 2011 and 2012, which has resulted in some degree of market stability. There was an increase in spending by employers in 2012, however, companies are still likely to look for

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<sup>42</sup> Laing & Buisson, *Private Acute Medical Care*, 2013, p39.

<sup>43</sup> *ibid*, p31

<sup>44</sup> *ibid*, pp32&33.

<sup>45</sup> *ibid*, p18.

<sup>46</sup> *ibid*, p22.

<sup>47</sup> *ibid*, p14

<sup>48</sup> *ibid*, p14.

savings where possible. Demand for individual policyholders continued to contract in 2012 at 1.5 per cent, however, a deceleration in the rate of contraction suggests that the decline may soon level off. Overall, the longer-term 'prosperity of health cover is dependent on employers' spending on health and wellness benefits overall and there are opportunities and threats for medical cover in a more mixed, more competitive, healthcare economy.<sup>49</sup>

### ***The patient pathway***

- 2.39 Competition in the private healthcare sector can be characterized as a contest for control of the patient pathway, since the destination of the patient determines the recipient of the payment for the patient's treatment. We now describe some of the different pathways that a patient might follow to receive treatment.

### ***The GP***

- 2.40 The pathway to private healthcare for most people starts with a visit to a GP,<sup>50</sup> who may be the patient's NHS GP or a doctor whose services are provided by their employer. The GP will assess the patient's condition and, if necessary, recommend that they see a specialist in the treatment of the condition that the GP has diagnosed (ie a consultant).
- 2.41 If the patient wishes to be treated privately, unless the condition is particularly rare or the treatment specialized, the GP will probably recommend a consultant<sup>51</sup> who practises locally.<sup>52</sup> Once the patient has decided which consultant to see, either the GP will contact the consultant, setting out the preliminary diagnosis and reasons for the referral, or will give the patient a letter of referral.
- 2.42 GPs in our survey told us that patients were more likely to know which hospital they wanted to use (44 per cent) than which consultant (28 per cent). This would be consistent with patients having some knowledge of local hospitals, but might also indicate that choice may be limited for many patients. It would also suggest that patients place greater reliance on GPs for advice on consultants than they do for advice on choice of hospital.
- 2.43 Patients in our survey said that they used their GP more than any other source of information regarding the choice of a consultant. It was especially the case for self-pay patients that they also researched both consultants and hospitals online. 16 per cent of patients said that they would have liked some further information, although could not identify the gaps in their information specifically.
- 2.44 Nearly half (47 per cent) of the GPs in our survey, on whom consumers clearly rely quite heavily for advice, felt that they lacked information as regards the fees charged by consultants, the length of time their patient would have to wait for an appointment and whether they were recognized by the patient's PMI. Just over a quarter of GPs

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<sup>49</sup> *ibid*, p18.

<sup>50</sup> In our [patient survey](#), 60 per cent of respondents said that they had been referred by a GP. Other pathways included a referral by one consultant to another or self-referral or referral from a PMI to, for example, a physiotherapist.

<sup>51</sup> In our [patient survey](#), 50 per cent of respondents said that their GP suggested a particular consultant, 20 per cent said that the GP did not refer them to a named consultant and 20 per cent said that their GP had suggested two or more consultants.

<sup>52</sup> In our [patient survey](#), the average travel time to a hospital being attended was just over 30 minutes. However, around half of all patients said that they would travel further if the GP recommended that they did so or if it was the only way they could see the consultant recommended. The proportion of those who felt their condition was severe or affected their life who would be willing to travel further was higher.

(26 per cent) felt they lacked information on consultants' clinical expertise, the factor they considered most important in making a referral.

### *Paying for privately-funded healthcare services*

- 2.45 Consumers wishing to receive private healthcare services may fund it in one of three ways:
- (a) they may pay for it themselves;
  - (b) they may seek reimbursement from their PMI under a policy they have taken out themselves; or
  - (c) they may seek reimbursement from their PMI under an employer's private medical cover scheme (see Appendix 2.1).
- 2.46 If the consumer does not have private health cover at all, or if they do but the condition is not covered by their policy or has certain excesses under their policy,<sup>53</sup> they will need to fund the treatment themselves if they wish to proceed. We refer to this form of funding as 'self-pay'. A consumer may elect to pay privately for healthcare services for a number of reasons. The treatment or procedure concerned may not be covered by their insurance policy or employer's scheme, for example cosmetic or bariatric surgery, or it may not be available at all through the NHS or only available after a long wait, for example IVF treatment or non-urgent surgery such as hernia repair. Most PMIs and hospital groups offer package pricing to self-pay patients. This means that even if a patient is not covered by a PMI policy, they may be able to access private treatment by buying a treatment package or paying a one-off price, which may include, for example, coverage for hospital charges and drugs for in-patients, a private room, nursing and medical care, and consultant and consultation fees. Package pricing usually requires a patient to pay in advance.<sup>54</sup>
- 2.47 If, as is more commonly the case, the consumer does have private cover, they may next contact their PMI or the organization which administers their employer's scheme (typically a PMI) to obtain the PMI's authorization to proceed with an initial, outpatient consultation.
- 2.48 PMIs tend to have fewer rules regarding outpatient consultations than for day-patient or inpatient treatment. They tend to recognize all or most private hospitals for outpatient consultations or treatments and set annual outpatient consultation fee maxima rather than operating a procedure-based fee schedule as they do for day-patient or inpatient treatment.<sup>55</sup> However, depending on the PMI, the patient may be informed at this stage that the consultant they are contemplating seeing may charge fees outside the PMI's fee maxima (a non-fee-assured consultant). If the patient prefers to see a non-fee-assured consultant, the PMI may inform them that they may be responsible to pay a top-up fee (a fee over and above the PMI's reimbursement maximum, which has been pre-agreed). PMIs' policies on top-up fees are considered in more detail in paragraphs 7.101 to 7.112.
- 2.49 The BMA survey of consultants indicates that the average fee for an initial outpatient consultation is around £170, with not much variation between specialties. However,

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<sup>53</sup> Most policies and schemes, for example, do not cover purely cosmetic surgical procedures or assisted conception treatments such as IVF.

<sup>54</sup> [www.netdoctor.co.uk/focus/selfpay/selfpay\\_pmi.htm](http://www.netdoctor.co.uk/focus/selfpay/selfpay_pmi.htm).

<sup>55</sup> Bupa, noting this, submitted that as a result, outpatient consultation fees had risen faster than other consultant costs (Bupa response to the issues statement, paragraph 6.79).

fees for an initial outpatient consultation vary regionally: the highest average fee was in London (£200) and the lowest in Wales (£123).<sup>56</sup>

### *The consultant—making the appointment*

- 2.50 The patient will then make an appointment to see the consultant (for the insured patient, once authorization has been obtained), usually at a private hospital.<sup>57</sup> The patient may have a choice of hospitals at which to see the consultant, as consultants usually have practising rights at more than one hospital.<sup>58</sup> However, in practice consultants tend to use one hospital as their main location, supplemented by one or two others. In our survey of consultants, 34 per cent said that they had treated patients at two hospitals in the previous 12 months, and 15 per cent said that they treated patients at three. 45 per cent, though, said that they had only seen patients at one hospital in the previous 12 months and 76 per cent said that they had treated three-quarters of their patients at one hospital.

### *The consultant—initial appointment*

- 2.51 The patient's next step is to see the consultant selected. The consultant may propose certain tests or types of examination before coming to a firm diagnosis, or may recommend a particular form of treatment, for example a surgical procedure. The insured patient may then re-contact their PMI to seek its authorization to proceed with the treatment recommended, the hospital or clinic proposed for the treatment and the consultant(s) who will be administering it.
- 2.52 Practice varies, but the PMI will typically check whether the consumer's policy or scheme covers the proposed procedure<sup>59</sup> and whether it entitles the consumer to use the hospital or clinic concerned.<sup>60</sup> The PMI will also usually check whether the consultant is 'fee assured' or recognized by it and, in some cases, whether the consultant has agreed to set their fees within the PMI's reimbursement rates.
- 2.53 In the case of surgical procedures, the patient may also need to provide the PMI with the name of the proposed anaesthetist, and the PMI may check whether they, like the surgeon, set their fees within the PMIs reimbursement rates.

### *Treatment and follow-up*

- 2.54 The patient will then proceed to the recommended treatment. On completion, the hospital and consultant will submit their bills (unless the patient has taken package pricing), probably direct to the payer. In some cases, where the payer is a PMI and where there are unforeseen or unexpected costs associated with treatment, the patient must pay a 'shortfall', the difference between the consultant's fee and the amount the PMI is willing to pay for that procedure.

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<sup>56</sup> BMA survey of consultant income, May 2011.

<sup>57</sup> The BMA survey indicated that 65 per cent of initial consultations took place at a private hospital.

<sup>58</sup> In our [GP and consultant survey](#), roughly two-thirds of consultants told us that they had practising rights at more than one private hospital.

<sup>59</sup> Including whether the consumer has a policy excess or has exhausted an annual claim limit, if any.

<sup>60</sup> The consumer should be aware of the hospitals and clinics they may attend as the list of these facilities will be available on joining an employer's scheme or from the PMI's promotional material.

- 2.55 The patient may be invited for a follow-up consultation by the consultant. A follow-up consultation generally takes less time than an initial consultation and the fee tends to be less (an average of £108 compared with £170 for an initial consultation).<sup>61</sup>

### *Variations*

- 2.56 Figure 2.7 illustrates some possible alternative patient pathways.<sup>62</sup> In one, the pathway is as described above: the patient visits a GP who makes a referral to a consultant who then treats the patient.
- 2.57 Variants illustrated include a guided referral where the patient obtains from their GP a referral letter which specifies the type of consultant recommended but not a named individual. The patient is then either guided to a consultant identified as appropriate by the PMI or to, for example, a physiotherapy clinic rather than, say, a consultant orthopaedic surgeon.<sup>63</sup>
- 2.58 In other cases, where a patient has cancer for instance, they may be referred by a consultant surgeon to another consultant (a clinical or medical oncologist for radio- or chemotherapy) and their treatment may be managed by a multidisciplinary team (MDT) rather than by an individual consultant.
- 2.59 While not a variant per se, in Scotland, the Scottish Care Information (SCI) Gateway is a national portal for healthcare communications that facilitates the exchange of patient-based clinical information and integrates GP practice systems and secondary care systems.<sup>64</sup>
- 2.60 For self-pay patients, a GP referral may not be necessary where, for example, a patient seeks IVF or cosmetic treatment.

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<sup>61</sup> BMA survey of consultant income, May 2011.

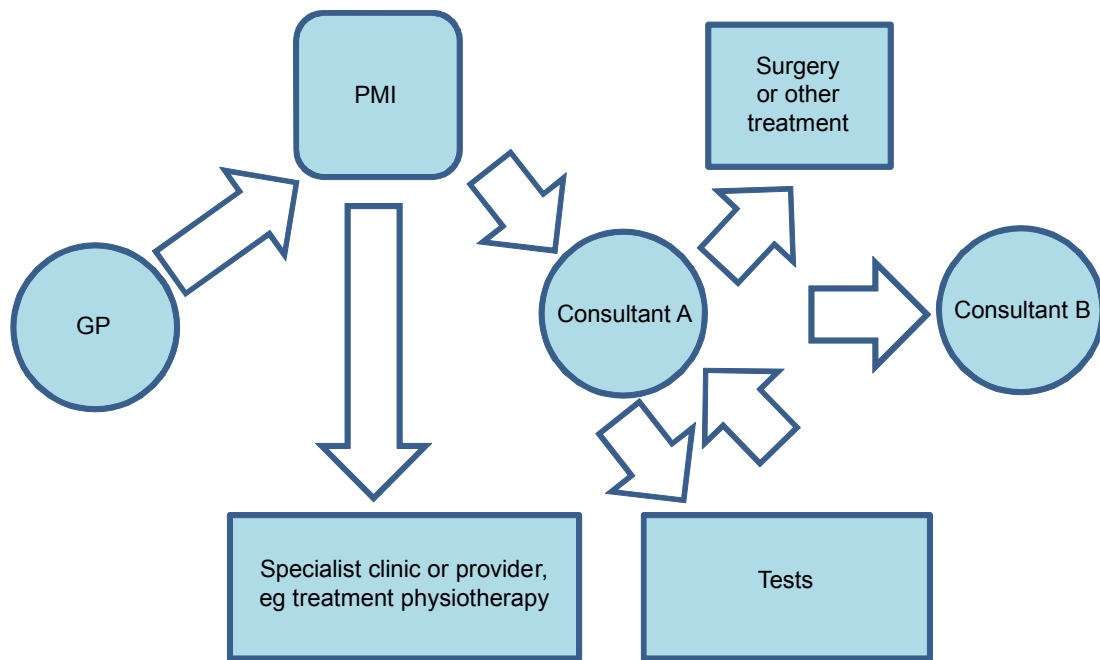
<sup>62</sup> The OFT research identified four pathways: GP led, self-led, NHS hospital-led and PMI-led. See [The Patient Journey](#).

<sup>63</sup> [X]

<sup>64</sup> [www.nisg.scot.nhs.uk/currently-supporting/sci-gateway](http://www.nisg.scot.nhs.uk/currently-supporting/sci-gateway).

FIGURE 2.7

### Consumer pathways to private healthcare



Source: CC.

### *The regulatory regime*

- 2.61 Regulation varies between the nations to some degree, and we have described differences where they arise.
- 2.62 There are three key spheres of regulation which apply to those operating in the private healthcare sector:
- (a) regulation of the quality and safety of private hospitals and clinics;
  - (b) regulation of clinicians practising in the private healthcare sector; and
  - (c) regulation of PMIs.
- 2.63 In addition, private healthcare providers are, of course, subject to non-sector-specific regulatory requirements relating to planning control, health and safety at work and, as regards commercial relations between doctors and hospitals, the Bribery Act 2010. We describe here the regulatory regime only as it applies specifically to those operating in the private healthcare sector.

### *Regulating private hospitals and clinics*

- 2.64 Oversight of private hospitals and clinics is divided between a number of different organizations whose roles are changing with the implementation of the Health and Social Care Act 2012 (the 2012 Act). Further, oversight provisions may differ between the nations and, where relevant, we indicate this.
- 2.65 Some of these organizations are regulators in the strict sense, but others may play an important role in the regulatory process in future, particularly as regards the

quality of service delivered by the regulated parties. We have therefore included these here too.

### *The healthcare regulators*

- 2.66 In England, the Care Quality Commission (CQC) is responsible for regulating, auditing and inspecting providers of healthcare (and adult social care) services, including services provided by private hospitals, GPs and other primary medical services. Its role is to register healthcare providers to ensure that they meet common safety and quality standards and, with Monitor, to develop a joint licensing process.<sup>65</sup> The CQC is responsible for inspecting healthcare facilities, and has enforcement powers including the imposition of fines, public warnings or closures if standards are not met.
- 2.67 In Scotland, the regulator is Healthcare Improvement Scotland,<sup>66</sup> which scrutinizes the quality and safety of care provided by NHS Scotland and the private sector.<sup>67</sup> In Wales, the Healthcare Inspectorate Wales ensures the safety and quality of health services by reviewing and inspecting standards in Welsh NHS bodies against a range of policies, guidance and regulations.<sup>68</sup> In Northern Ireland, the Regulation and Quality Improvement Authority is an independent body that is responsible for monitoring and inspecting the availability and quality of health and social care services through registration and inspection.<sup>69</sup>

### *Monitor*

- 2.68 Monitor is the sector regulator for health services in England. It is currently responsible for supporting NHS Trusts in becoming Foundation Trusts, assessing whether NHS Trusts are ready to be Foundation Trusts, and ensuring that Foundation Trusts comply with their obligations and are well led and financially robust. It also regulates price and choice for NHS services and anti-competitive behaviour by commissioners and healthcare providers.
- 2.69 The 2012 Act makes changes to the way healthcare is regulated in England, and Monitor's role is changing significantly as a result. Under the new legislation, from 1 April 2014, Monitor will regulate all providers of NHS-funded services in England with turnover of over £10 million per annum (including private hospitals providing services to the NHS<sup>70</sup>), through its licensing scheme. In addition to being registered by the CQC, all providers of NHS-funded services in England will need to be licensed by Monitor. Monitor will use the provider licence to fulfil many of its new duties in relation to setting prices for NHS-funded care in partnership with the NHS Commissioning Board, enabling integrated care, preventing anticompetitive conduct, and supporting commissioners in maintaining service continuity.<sup>71</sup> Monitor's role will continue to encompass supervision and interpretation of the private patient income cap rules.<sup>72</sup>

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<sup>65</sup> The CQC will thus register independent hospitals, but NHS Trusts will not have to register PPUs separately.

<sup>66</sup> [www.healthcareimprovementscotland.org/programmes/inspecting\\_and\\_regulating\\_care/independent\\_regulation.aspx](http://www.healthcareimprovementscotland.org/programmes/inspecting_and_regulating_care/independent_regulation.aspx).

<sup>67</sup> *NHS Handbook 2012–13*, p213.

<sup>68</sup> *ibid* p227.

<sup>69</sup> *ibid* p235.

<sup>70</sup> [www.monitor.gov.uk/sites/default/files/publications/About%20Monitor%20-%20August%202013.pdf](http://www.monitor.gov.uk/sites/default/files/publications/About%20Monitor%20-%20August%202013.pdf).

<sup>71</sup> [www.monitor-nhsft.gov.uk/sites/default/files/publications/ToPublishLicenceDoc14February.pdf](http://www.monitor-nhsft.gov.uk/sites/default/files/publications/ToPublishLicenceDoc14February.pdf).

<sup>72</sup> On 1 October 2012, the cap increased to 49 per cent of a Foundation Trust's income.



### *National Institute for Health and Care Excellence and equivalent organizations*

- 2.70 The National Institute for Health and Care Excellence (NICE) develops quality standards and promotes best practice for the NHS in England and Wales. In Scotland, two bodies perform similar functions: the Scottish Medicines Consortium provides advice to NHS Boards and their Area Drug and Therapeutics Committees across Scotland about the status of newly-licensed medicines, formulations of existing medicines and new indications for established products and works to 'improve financial and service planning within NHS Boards through the provision of early intelligence on new medicines in development',<sup>73</sup> and the Scottish Intercollegiate Guidelines Network develops evidence-based clinical practice guidelines for the NHS in Scotland.<sup>74</sup>
- 2.71 NICE guidance is made available to NHS Scotland healthcare professionals by Health Improvement Scotland,<sup>75</sup> and links exist between NICE and the Northern Ireland Executive to enable NICE guidelines to be reviewed for their applicability to Northern Ireland.<sup>76</sup> NICE is developing a library of quality standards to provide guidance to clinicians, commissioners and patients.<sup>77</sup> These efforts will be reinforced through incentive payments to healthcare providers through the Commissioning for Quality and Innovation (CQUIN) scheme.<sup>78</sup>

### *Department of Health*

- 2.72 Whilst, again, not strictly a 'regulatory' body, the Department of Health (DoH) in England and its associated bodies (formerly the Primary Care Trusts and Strategic Health Authorities, now the NHS Commissioning Board, the regional commissioning boards and the clinical commissioning groups), as purchasers of privately-funded healthcare services, have an important role in monitoring quality and intervening when problems arise. For example, the 2013 Francis inquiry into the Mid Staffordshire NHS Foundation Trust recommended that the DoH ensure that procedures are put in place to facilitate the identification of patient safety issues by training regulators and ensuring competition between them, through the NHS Commissioning Board devising enhanced quality standards for the healthcare service (for enforcement by the CQC) and obtaining information from providers about their compliance with standards in annual quality accounts.<sup>79</sup>
- 2.73 Purchasing of privately-funded healthcare services in the nations is far less significant. However, part of Welsh Assembly Government policy to improve patient quality of care is to set national minimum standards for private healthcare providers, and in Scotland for example, the Government provides guidance to NHS Boards regarding situations where patients receive private healthcare in addition to NHS care. The Health and Social Care Board in Northern Ireland has responsibility for commissioning health services for the public and ensuring that these are sufficient to meet the needs of the population.

### *Independent Healthcare Advisory Services*

- 2.74 Independent Healthcare Advisory Services (IHAS) is a trade body representing private healthcare providers, which focuses on improving the quality and safety of

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<sup>73</sup> [www.scottishmedicines.org.uk/About\\_SMC/What\\_we\\_do/Remit](http://www.scottishmedicines.org.uk/About_SMC/What_we_do/Remit).

<sup>74</sup> <http://sign.ac.uk/about/index.html>.

<sup>75</sup> [www.healthcareimprovementscotland.org/programmes/nice\\_guidance\\_and\\_scotland.aspx](http://www.healthcareimprovementscotland.org/programmes/nice_guidance_and_scotland.aspx).

<sup>76</sup> [www.nice.org.uk/niceMedia/pdf/2006-030-NI-Executive-formalises-link-with-NICE.pdf](http://www.nice.org.uk/niceMedia/pdf/2006-030-NI-Executive-formalises-link-with-NICE.pdf).

<sup>77</sup> [www.nice.org.uk/aboutnice/qualitystandards/qualitystandards.jsp](http://www.nice.org.uk/aboutnice/qualitystandards/qualitystandards.jsp).

<sup>78</sup> [www.institute.nhs.uk/world\\_class\\_commissioning/pct\\_portal/cquin.html](http://www.institute.nhs.uk/world_class_commissioning/pct_portal/cquin.html).

<sup>79</sup> [www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf](http://www.midstaffspublicinquiry.com/sites/default/files/report/Executive%20summary.pdf).



healthcare provision by its member organizations, which include each of the major hospital operators in the UK.<sup>80</sup>

## *Regulating doctors*

### *The GMC, the royal colleges and Local Education and Training Boards*

- 2.75 The GMC registers doctors to practise medicine in the UK.<sup>81</sup> It is overseen by the Professional Standards Authority for Health and Social Care, a statutory body responsible to Parliament and charged with promoting best practice and consistency in professional self-regulation in nine bodies responsible for different branches of the healthcare profession across the whole of the UK.
- 2.76 To treat patients, a doctor must be registered with the GMC and have a licence to practise. From December 2012, doctors have to renew their licence periodically through revalidation, the process by which doctors must demonstrate to the GMC that they are up to date and fit to practise.<sup>82</sup>
- 2.77 The GMC publishes advice to doctors on the standards expected of them. All doctors must follow the advice given in the GMC's *Good Medical Practice*<sup>83</sup> and its explanatory guidance, which includes advice on avoiding and dealing with conflicts of interest.
- 2.78 The GMC's *Good Medical Practice*, which was updated in April 2013, precludes doctors from accepting any inducement, including financial incentives, that may affect or be seen to affect the way that they treat or refer a patient or commission services—if they have a financial interest in a hospital or clinic to which they plan to refer a patient, this must be disclosed to the patient and recorded in the patient's notes.
- 2.79 The medical royal colleges are each responsible for a different specialty within the medical field.<sup>84</sup> The medical royal colleges are charged with setting standards within their field and for supervising the training of consultants within that specialty.
- 2.80 Local Education and Training Boards (which incorporate the former NHS deaneries) and foundation schools for the NHS are responsible for the management and delivery of postgraduate medical education and for supporting the continuing professional development of all doctors.<sup>85</sup>

### *Other organizations*

- 2.81 Some other organizations are relevant to doctors' revalidation in particular, and the promotion of service quality more generally:
- (a) the Academy of Medical Royal Colleges; and
  - (b) the Doctors and Dentists Pay Review Body (DDRB).

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<sup>80</sup> [www.independenthealthcare.org.uk/](http://www.independenthealthcare.org.uk/).

<sup>81</sup> [www.gmc-uk.org/about/index.asp](http://www.gmc-uk.org/about/index.asp).

<sup>82</sup> [www.gmc-uk.org/doctors/licensing.asp](http://www.gmc-uk.org/doctors/licensing.asp).

<sup>83</sup> [www.gmc-uk.org/guidance/good\\_medical\\_practice.asp](http://www.gmc-uk.org/guidance/good_medical_practice.asp).

<sup>84</sup> See paragraph 3.58.

<sup>85</sup> [www.nhscareers.nhs.uk/explore-by-career/doctors/letbs-and-foundation-schools/](http://www.nhscareers.nhs.uk/explore-by-career/doctors/letbs-and-foundation-schools/).

- *The Academy of Medical Royal Colleges*

2.82 The Academy facilitates the work of the medical royal colleges, in particular the development of specialty-specific guidance on training and supporting information, and the development of quality assurance proposals.

- *The Doctors and Dentists Pay Review Body*

2.83 Under the Clinical Excellence Awards scheme in England, clinicians may be awarded annual payments in addition to their salary in recognition of their contribution to the NHS. Awards are made at regional and national level at different levels, the highest of which is 'Platinum' which attracts an annual award of over £75,000.<sup>86</sup> In 2012, DDRB carried out a review of the scheme. It recommended that there should be a stronger link between awards and performance appraisals and improved links between awards to outcomes such as quality of patient care.<sup>87</sup>

## Regulating PMIs

### *The Financial Conduct Authority*

2.84 Until April 2013, PMIs in the UK were regulated by the FSA. On 1 April 2013, the FSA was abolished and the majority of its functions transferred to two new regulators: the Prudential Regulation Authority (PRA) and the FCA. The FCA inherited the majority of the FSA's roles and functions and, for the short term at least, adopted the FSA handbooks.

2.85 In 2006/07, the FSA simplified its rules and guidance relating to the sale of insurance products (eg rules relating to product disclosure and claims handling). This change of approach is reflected in the FSA's new *Insurance: Conduct of Business Sourcebook* (ICOBs) which replaced *Insurance: Conduct of Business* sourcebook (ICOB). In 2010, the FSA carried out a review of the changes to assess whether they had resulted in consumer detriment in any insurance sector(s).

2.86 In the PMI sector, the FSA had removed a mandatory requirement that insurers provide consumers with a policy summary before a contract is concluded. In its review, it did not find evidence of a widespread reduction in the amount of information available to consumers about insurance policies as a result of the change—many PMIs maintained their previous practices. It found that the core level of cover offered by PMI products and consumers' ability to make value-for-money purchases and understand insurance products were not materially affected following the change to approach in regulation. It acknowledged that the potential for consumer detriment caused by a lack of understanding at the point of sale was greater for PMI than other general insurance products, due to its complexity. However, overall it considered that the PMI market generally worked well for consumers.<sup>88</sup>

### *Association of British Insurers*

2.87 Whilst not a regulator, the ABI has produced a 'Statement of Best Practice for Sales of Individual and Group Private Medical Insurance'.<sup>89</sup> The ABI said that the

<sup>86</sup> [www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH\\_132860](http://www.dh.gov.uk/en/Publicationsandstatistics/Publications/AnnualReports/DH_132860), p25.

<sup>87</sup> [www.gov.uk/government/uploads/system/uploads/attachment\\_data/file/226727/DDRB\\_CEA\\_Cm\\_8518.pdf](http://www.gov.uk/government/uploads/system/uploads/attachment_data/file/226727/DDRB_CEA_Cm_8518.pdf).

<sup>88</sup> [www.fsa.gov.uk/pubs/other/icobs\\_review.pdf](http://www.fsa.gov.uk/pubs/other/icobs_review.pdf).

<sup>89</sup> [www.abi.org.uk/~media/Files/Documents/Publications/Public/Migrated/Health/ABI%20statement%20of%20best%20practice%20for%20sales%20of%20individual%20and%20group%20private%20medical%20insurance.ashx](http://www.abi.org.uk/~media/Files/Documents/Publications/Public/Migrated/Health/ABI%20statement%20of%20best%20practice%20for%20sales%20of%20individual%20and%20group%20private%20medical%20insurance.ashx).

Statement was in addition to any regulatory or legal requirements and was mandatory for all PMIs that were ABI members. It said that the code could therefore be taken into account by the Financial Ombudsman Service (FOS).<sup>90</sup>

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<sup>90</sup> The FOS is the statutory dispute resolution scheme set up under the Financial Services and Markets Act 2000 and the Consumer Credit Act 2006.

### **3. The parties**

- 3.1 Following our description of the industry background in Section 2, in this section, we describe in more detail the major parties to the investigation, namely the private hospitals and hospital groups, clinicians and PMIs.

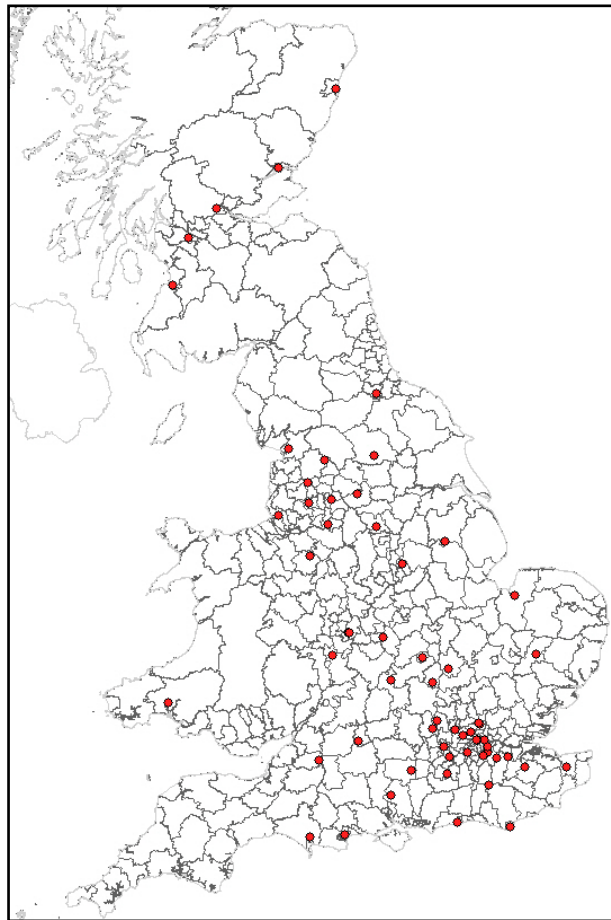
#### ***The main hospital groups***

##### ***BMI Healthcare***

- 3.2 BMI Healthcare (BMI) is the largest private hospital operator in the UK. It is the trading subsidiary of General Healthcare Group (GHG). BMI operates 69 hospitals and treatment centres, including three hospitals (Three Shires Hospital, Foscote Hospital and McIndoe Surgical Centre) managed for third parties or JVs and a number of NHS PPUs, including the Coombe wing at Kingston Hospital in Surrey. BMI's hospitals have a combined overnight bed capacity of 2,711 (see Figure 3.1). BMI operates a number of JV arrangements with consultants. As discussed elsewhere (see paragraphs 8.15 and 8.16), it also offered a consultant incentive scheme in Bath that was designed to mimic the equity ownership model of Circle.
- 3.3 GHG was formed in the 1980s by the US provider American Medical International. In 1997, it was acquired by Cinven together with GHG's French sister company Générale de Santé and merged with Amicus, which Cinven had formed in 1995 from the hospital interests of Compass Group. In 2000, GHG was acquired by BC Partners, a private equity group, which subsequently sold GHG's psychiatric and occupational health services businesses. In 2006, a consortium led by Netcare acquired the business for £2.35 billion. Netcare itself now has a 53.7 per cent share of GHG, with the remainder being owned by a consortium of UK investors comprising Apax Partners Worldwide LLP and London and Regional Properties, and the balance held by management and senior staff.

FIGURE 3.1

**BMI portfolio of hospitals**



Source: BMI.

- 3.4 BMI has expanded in the UK, including via a number of acquisitions. In 2008, BMI acquired nine hospitals from Nuffield Health, and in 2010 it acquired the Abbey Hospitals' portfolio of four hospitals (two near Liverpool and two in Scotland). Both transactions resulted in OFT inquiries, and as a result BMI sold two of the Nuffield hospitals (to Spire Healthcare and Ramsay Health Care) and agreed to divest one of the Abbey hospitals. However, BMI was unable to find a suitable purchaser for that Abbey hospital and was released from its obligation to sell by the OFT in March 2011.
- 3.5 In 2008, BMI bought a majority stake in the 22-bed Oxford Clinic for Specialist Surgery. This business was sold to Nuffield in 2012 and the unit subsequently closed. In 2008, BMI also acquired the 38-bed Woodlands Hospital in Darlington and a private GP business, City Medical, with two consulting suites in central London.
- 3.6 In 2009, BMI acquired the Fitzroy Square Hospital in London and a stake in Phoenix Hospital Group which operated a 17-bed hospital in Weymouth Street and a consulting and diagnostic clinic in Harley Street. Also in 2009, it secured the contract to operate the 22-bed Coombe Wing at Kingston Hospital.
- 3.7 During 2010, BMI established a JV with Sentosa UK to run Syon Clinic in Brentford and acquired a stake in the Phoenix day-surgery hospital in Southend (now the BMI Southend Hospital).

- 3.8 Table 3.1 provides a summary of the financial performance of General Healthcare Mixer Partnership LLP (which includes both BMI OpCo and GHG PropCo combined) between FY07 and FY11. BMI has experienced rapid growth in revenues from NHS patients, while revenues from self-pay patients have declined over the same period. Following its leveraged buyout in 2006, BMI is highly geared with significant annual interest expenses.

TABLE 3.1 General Healthcare Mixer Partnership LLP\* summary financial information

	£'000				
	FY07	FY08	FY09	FY10	FY11
Insured patients	[X]	[X]	[X]	[X]	[X]
Self-pay patients	[X]	[X]	[X]	[X]	[X]
NHS patients	[X]	[X]	[X]	[X]	[X]
Other	[X]	[X]	[X]	[X]	[X]
Total revenue	683,642	778,320	830,436	850,644	886,398
Gross profit	[X]	[X]	[X]	[X]	[X]
EBITDA	[X]	[X]	[X]	[X]	[X]
Interest expense	[X]	[X]	[X]	[X]	[X]
Capital expenditure	[X]	[X]	[X]	[X]	[X]
Total debt	[X]	[X]	[X]	[X]	[X]
Cash	[X]	[X]	[X]	[X]	[X]
Net debt	[X]	[X]	[X]	[X]	[X]

Source: BMI.

\*Summary of financial information includes both BMI OpCo and GHG PropCo combined.

- 3.9 In FY11, BMI admitted approximately 280,000 patients for treatment. Figure 3.2 shows the rapid growth in NHS admissions at BMI hospitals between FY08 and FY11. In contrast, the number of private patients declined from FY09/FY10 onwards.

FIGURE 3.2

### BMI inpatient and day-patient admissions, FY07 to FY11

[X]

Source: BMI.

### Spire Healthcare

- 3.10 Spire is the second largest private hospital operator in the UK, with 38 hospitals and 31 satellite clinics<sup>91</sup> located throughout England, Wales and Scotland. The Spire business was acquired by funds managed or advised by Cinven (a private equity firm), which acquired the business in two stages, reassembling the portfolio of hospitals that had been owned by Bupa. The first stage involved the buyout of Bupa Hospitals in August 2007 and the second involved the acquisition of the Classic Hospitals Group in February 2008.<sup>92</sup> Spire later acquired the Gerrards Cross private hospital (now known as Spire Thames Valley) from BMI Healthcare in March 2008.

<sup>91</sup> These satellite clinics generally offer consulting rooms and a range of outpatient and diagnostic services. In some cases, they may also have facilities for minor surgical procedures.

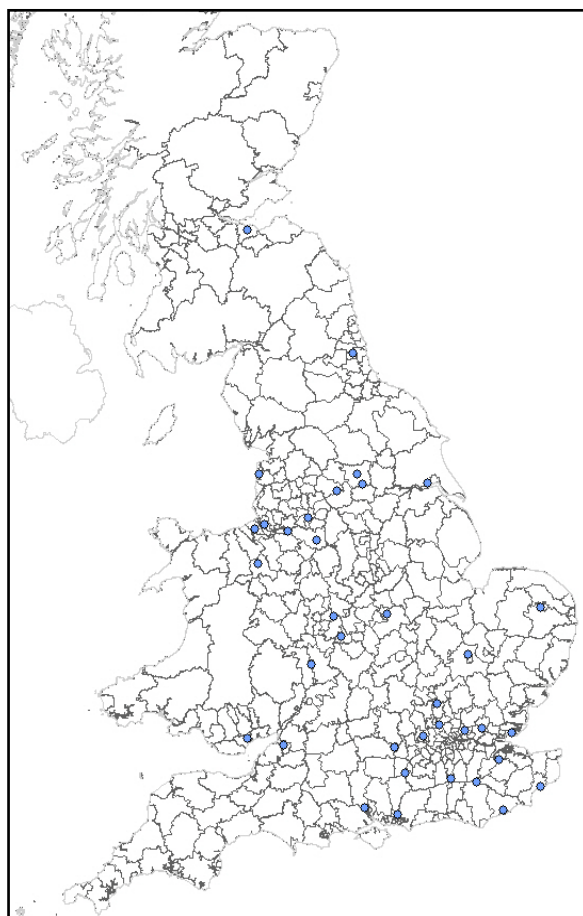
<sup>92</sup> The Classic Hospitals portfolio had been part of Bupa Hospitals but was sold to Legal & General Ventures in 2005.

As at 3 October 2012, Spire's facilities comprised 116 theatres, 479 consulting rooms, 1,564 overnight beds and 210 day-beds.

- 3.11 Spire has invested heavily in developing its service offering in recent years, acquiring 12 MRI and 16 CT scanners for its hospitals as well as expanding its theatre capacity in a number of areas. Spire has pursued a strategy of increasing its ability to provide higher acuity treatments to patients. Spire also operates a limited number of JVs, for example, the Montefiore Hospital in Brighton, based on a model not unlike that of Circle except that consultants are required to invest up front rather than pay for their equity share only when they wish to dispose of it.
- 3.12 Figure 3.3 shows the location of Spire's portfolio of hospitals.

FIGURE 3.3

### Spire portfolio of hospitals



Source: Spire.

- 3.13 Table 3.2 provides a summary of the financial performance of Spire between FY07 and FY11. Spire has grown both its revenues and its margins significantly over the period, with the latter resulting largely from improvements in efficiency. Revenues from NHS patients have [X]. Following its leveraged buyout in 2007 and the subsequent acquisition of the Classic Hospitals Group, [X].

TABLE 3.2 Spire summary financial information

	£'000				
	FY07	FY08	FY09	FY10	FY11
Insured patients	[X]	[X]	[X]	[X]	[X]
Self-pay patients	[X]	[X]	[X]	[X]	[X]
NHS patients	[X]	[X]	[X]	[X]	[X]
Other	[X]	[X]	[X]	[X]	[X]
Total revenue	[X]	[X]	[X]	[X]	[X]
Gross profit	[X]	[X]	[X]	[X]	[X]
EBITDA	[X]	[X]	[X]	[X]	[X]
Interest expense	[X]	[X]	[X]	[X]	[X]
Capital expenditure	[X]	[X]	[X]	[X]	[X]
Debt*	[X]	[X]	[X]	[X]	[X]
Cash	[X]	[X]	[X]	[X]	[X]
Net debt	[X]	[X]	[X]	[X]	[X]

Source: Spire.

\*[X]

- 3.14 Figure 3.4 shows the composition of Spire's inpatient and day-patient admissions between FY07 and FY11. [X]

FIGURE 3.4

### Spire inpatient and day-patient admissions, FY07 to FY11

[X]

Source: Spire.

### Hospital Corporation of America

- 3.15 HCA is the third-largest provider of healthcare services in the UK and the largest in London by revenue. HCA UK is a subsidiary of HCA Holdings Inc, the largest hospital group in the US. HCA Holdings operates 163 hospitals and 109 surgery centres in the US and is listed on the New York stock exchange. In 2011, HCA UK generated turnover of £[X] and EBITDA of £[X] from its hospital operations in the UK. It admitted around [X] patients and treated a further [X] on an outpatient basis.
- 3.16 HCA began providing private healthcare in the UK in 1996 with its purchase of a 50 per cent share in the Harley Street Clinic, Wellington, Princess Grace and Portland hospitals, in a JV with what was, at the time, PPP Healthcare. HCA expanded in 2000, buying out PPP Healthcare's share in the JV. HCA also acquired St Martin's Healthcare (comprising the London Bridge, Lister and Devonshire<sup>93</sup> hospitals) in 2000 from the Kuwait Investment Office.<sup>94</sup> HCA submitted to us that it had significantly invested in each of these hospitals.

<sup>93</sup> The Devonshire Hospital was converted into an outpatient and diagnostic facility.

<sup>94</sup> HCA [website](#).



- 3.17 HCA has also created or acquired a number of outpatient and diagnostic clinics and developed a new ambulatory care centre (the Wellington Hospital Platinum Medical Centre), as well as winning competitive bids to operate three NHS PPUs including, in London, University College Hospital (UCH) (incorporating Harley Street at UCH and a private patient unit within the MacMillan Cancer Centre for outpatient and day-patient treatments),<sup>95</sup> Queens Hospital (Romford) and, most recently, Guy's and St Thomas' Hospital where HCA will manage a PPU within the Trust's new Cancer Treatment Centre (due to open in 2016).<sup>96</sup>
- 3.18 In 2010, HCA expanded outside the Greater London area for the first time, winning a tender to develop jointly a new private patient cancer centre at the Christie NHS Foundation Trust Hospital in Manchester, the Christie Clinic. The Christie Clinic is the UK's largest specialist cancer treatment centre outside of London. In spring 2014, HCA will open a new facility (52 Alderley Road) in South Manchester with advanced diagnostics, treatments and surgical procedures for a wide range of medical conditions.<sup>97</sup> HCA is also looking to further expand in South Manchester and has been appointed preferred bidder for a new PPU project at the MediPark development in Wythenshawe. If [X] and HCA is successfully awarded the contract, it is likely to involve the development of [X]. It is estimated that the facility would open in [X].
- 3.19 HCA currently has a total of 416 consulting rooms, 44 theatres, 790 overnight beds and 167 day-beds across its UK hospitals. HCA has invested in its critical care offering so that all of HCA's main hospitals have an intensive care unit and are capable of offering HDU (high dependency unit) services too. These facilities, HCA's investment in building clinical and nursing support teams, and new medical technology such as the CyberKnife Robotic Radiosurgery System, all support the high-acuity work carried out at HCA hospitals. HCA also has a number of JV relationships with consultants, in six cases with consultants who have invested in the JV alongside HCA and in other cases with HCA buying equity in a vehicle created by a group of consultants.<sup>98</sup>
- 3.20 Figure 3.5 shows the location of HCA's hospitals and PPUs.

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<sup>95</sup> [www.harleystreetatuch.co.uk/the-uch-macmillan-cancer-centre/](http://www.harleystreetatuch.co.uk/the-uch-macmillan-cancer-centre/).

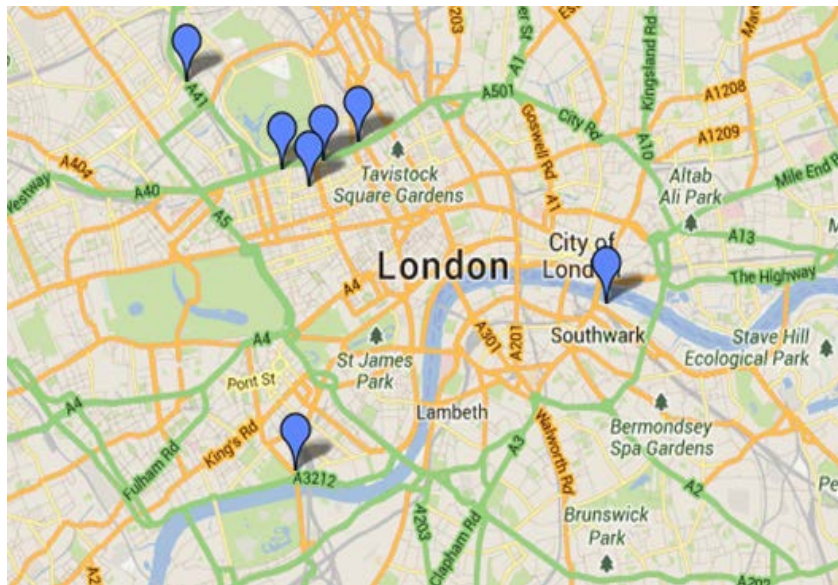
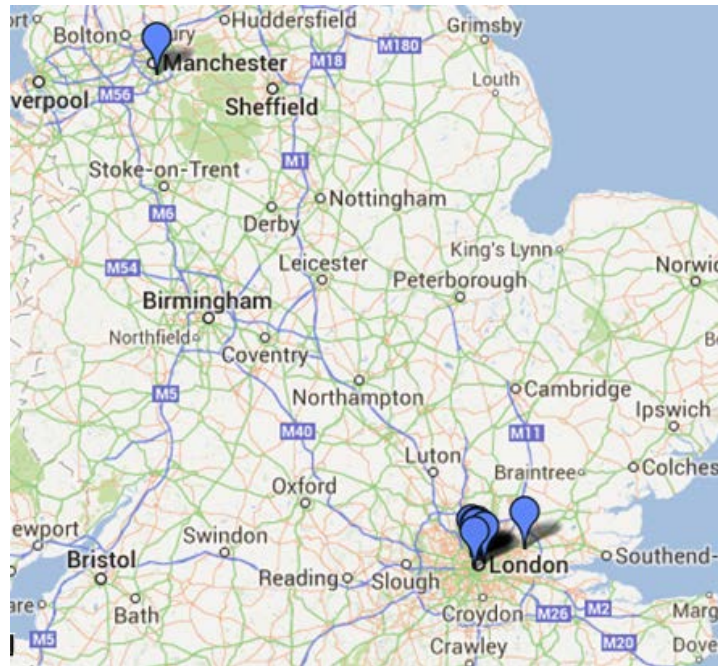
<sup>96</sup> HCA outpatient clinics include the Platinum, New Malden, Chelsea, Brentwood, City of London, Old Broad Street, Docklands and Sevenoaks medical centres. OFT decision regarding HCA and Guy's and St Thomas' commercial agreement: [www.of.gov.uk/shared\\_of/mergers\\_ea02/2012/HCA.pdf](http://www.of.gov.uk/shared_of/mergers_ea02/2012/HCA.pdf).

<sup>97</sup> See website: <http://www.52alderleyroad.co.uk>.

<sup>98</sup> HCA has a number of joint ventures with entities including the London Oncology Clinic, the Harley Street Clinic at the Groves, Chelsea Outpatient Centre, Robotic Radiosurgery and Wellington Diagnostic Services. In addition, HCA has six types of agreements that it may offer to consultants: Consulting Room Licence Agreements, Fully Managed Practice Agreements, Professional Service Agreements, Recruitment Agreements, Recruiting Agreements and Galen Consultant Agreements.

FIGURE 3.5

### HCA's portfolio of hospitals



Source: HCA.

- 3.21 In addition to its secondary care facilities, HCA has invested in the primary care sector, albeit to a relatively smaller extent, by acquiring an ownership interest in three providers of private GP surgeries and occupational healthcare providers: Blossoms Healthcare (April 2012), Roodlane (August 2011) and General Medical Clinics (July 2012).
- 3.22 Table 3.3 provides a summary of the financial performance of HCA between FY07 and FY11. HCA does minimal quantities of NHS work but does earn a significant proportion of its revenues from overseas patients. HCA UK is financed as part of HCA Holdings Inc.

TABLE 3.3 HCA summary financial information\*

	£'000				
	FY07	FY08	FY09	FY10	FY11
Insured patients	[X]	[X]	[X]	[X]	[X]
Self-pay patients	[X]	[X]	[X]	[X]	[X]
Overseas patients	[X]	[X]	[X]	[X]	[X]
Other	[X]	[X]	[X]	[X]	[X]
Total revenue	[X]	[X]	[X]	[X]	[X]
Gross profit	[X]	[X]	[X]	[X]	[X]
EBITDA†	[X]	[X]	[X]	[X]	[X]
Capital expenditure	[X]	[X]	[X]	[X]	[X]

Source: HCA.

\*[X]  
†[X]

- 3.23 Figure 3.6 shows the number of inpatient and day-patient admissions to HCA hospitals over the 2007 to 2011 period. Total admissions increased by [X] overall, with the number of [X] patients being treated by HCA increasing more rapidly than other types of patients.

FIGURE 3.6

### HCA inpatient and day-patient admissions, FY07 to FY11

[X]

Source: HCA

### Nuffield Health

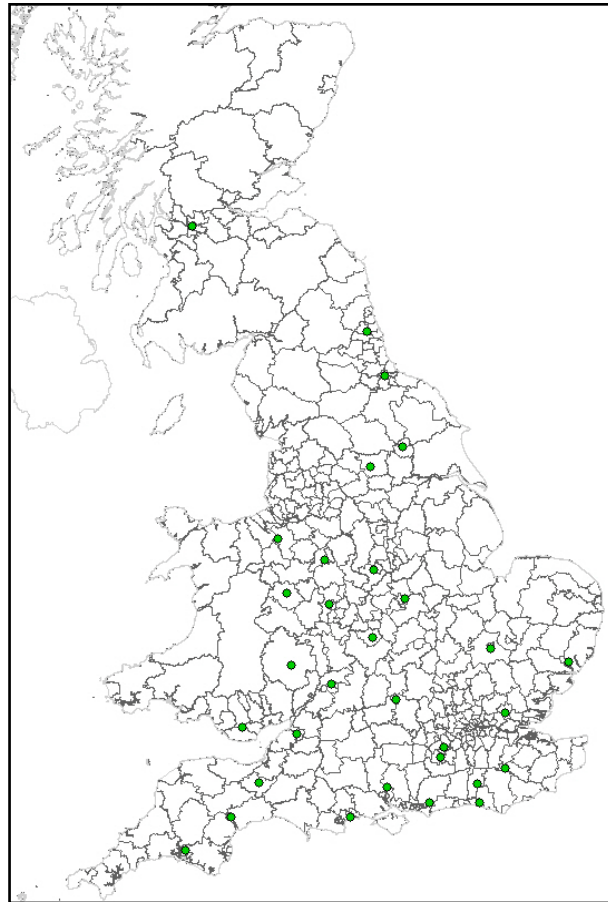
- 3.24 Nuffield Health (Nuffield), a registered charity, is the fourth largest private hospital group in the UK by revenue and the largest of the not-for-profit providers. It operates 31 hospitals with a total of 1,345 inpatient beds. Nuffield was established in the late 1950s by Bupa to acquire and build new community hospital facilities to offer choice in healthcare. It began initially by renovating nursing homes, but then opened purpose-built hospitals. Its first new hospital was opened in Woking in 1962.
- 3.25 Nuffield is an independent not-for-profit organization. It has neither shareholders nor investors, and its surplus is put back into its hospitals' infrastructure, refurbishments and staff. As a charity, it may benefit from some tax advantages.<sup>99</sup>
- 3.26 Between 2000 and 2004, Nuffield acquired five hospitals and built five new ones to replace existing facilities. In 2008, it sold nine of its hospitals to GHG in a transaction cleared by the OFT and subsequently sold its hospital in Hull to the NHS. It opened the Vale clinic in South Wales in a JV with a consultant-led partnership based in Cardiff and, in another venture with a clinician group, Independent Healthcare Specialists, opened a day-patient clinic in Guildford in 2009. In 2010, Nuffield acquired full ownership of both hospitals. In 2012, Nuffield acquired BMI's Oxford

<sup>99</sup> [www.hmrc.gov.uk/charities/tax/basics.htm](http://www.hmrc.gov.uk/charities/tax/basics.htm).

clinic from GHG and integrated it into its Nuffield Manor Hospital. Figure 3.7 shows the location of Nuffield's hospitals in the UK.

FIGURE 3.7

**Nuffield portfolio of hospitals**



Source: Nuffield.

- 3.27 Table 3.4 provides a summary of the financial performance of Nuffield between FY07 and FY11. Total revenue has increased slightly over the period, with EBITDA fluctuating significantly (largely as a result of the sale of hospitals).

TABLE 3.4 Nuffield summary financial information

	£'000				
	FY07	FY08	FY09	FY10	FY11
Insured patients	[X]	[X]	[X]	[X]	[X]
Self-pay patients	[X]	[X]	[X]	[X]	[X]
NHS patients	[X]	[X]	[X]	[X]	[X]
Other	[X]	[X]	[X]	[X]	[X]
Total revenue	[X]	[X]	[X]	[X]	[X]
Gross profit	[X]	[X]	[X]	[X]	[X]
EBITDA	[X]	[X]	[X]	[X]	[X]
Capital expenditure	[X]	[X]	[X]	[X]	[X]

Source: Nuffield.

[X]

3.28 Nuffield's overall health strategy over the last ten years has been to move towards both prevention and cure. This strategic direction led to Nuffield purchasing Sona Healthcare in 2005, Health Club Investment Group, parent of Cannons Health and Fitness in 2007, Bladerunner in 2010 and Greens Health and Fitness in 2012. These acquisitions have seen the group now running 65 Fitness and Wellbeing centres and nearly 200 corporate sites as well as the 31 hospitals. The prevention aspect of its strategy has seen the group look to find synergies between private hospitals and wellness and fitness services offering health assessments and a range of services in the health and fitness facilities that it operates.

3.29 Figure 3.8 shows how the composition of Nuffield's admissions has changed between 2007 and 2011, with growth in the number of NHS patients offsetting a decline in the number of private patients.

FIGURE 3.8

### Nuffield inpatient and day-patient admissions, 2007 to 2011

[X]

Source: Nuffield.

### Ramsay Health Care

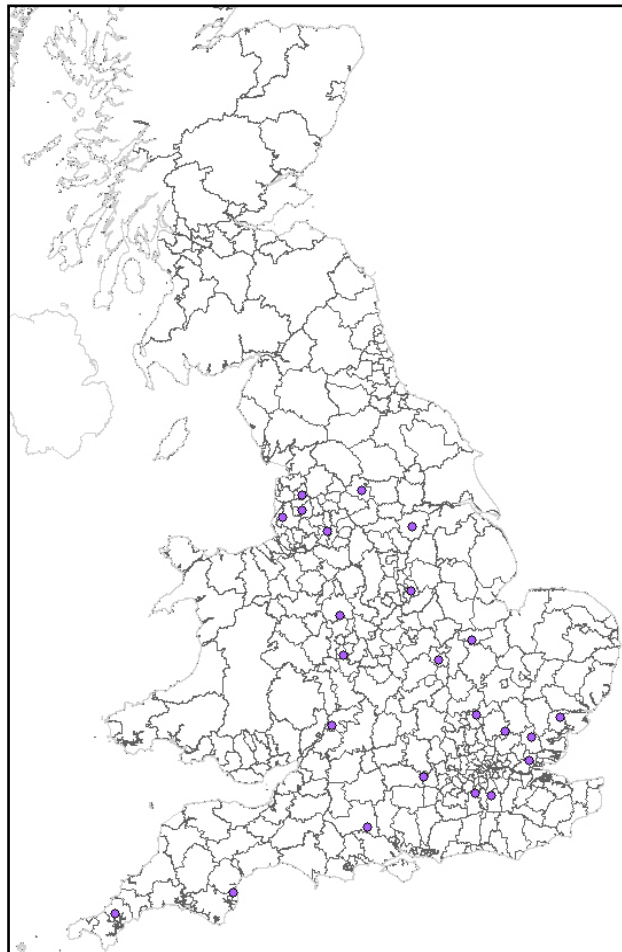
3.30 Ramsay is the UK's fifth largest private hospital operator with 30 hospitals with 947 beds, including two Independent Sector Treatment Centres (ISTCs). Ramsay also operates a PPU on behalf of Basildon and Thurrock University NHS Foundation Trust.

3.31 Ramsay is the largest private hospital operator in Australia and also operates in France and Indonesia. It entered the UK market in 2007 with its purchase of Capio Healthcare's UK hospital operating business. Capio AB, a Swedish private equity investor, had acquired Community Hospitals Group in 2001 and was itself acquired in 2006 by a partnership between Apax Partners and Nordic Capital. The new owner sold its hospital premises to the Prestbury Consortium which leased them back to Capio before it sold the hospital operation business to Ramsay.

3.32 Figure 3.9 shows the locations of Ramsay's hospitals in the UK.

FIGURE 3.9

**Ramsay portfolio of hospitals**



Source: Ramsay.

- 3.33 Ramsay differs from the other major private hospital operators in the amount of work it undertakes for the NHS across a range of procedures including, for example, hip and knee replacements (see Figure 3.10). Between 2008 and 2012, Ramsay substantially increased the number of NHS patients treated at its facilities, allowing it to grow total admissions by [X] per cent over the period.

FIGURE 3.10

**Ramsay inpatient and day-patient admissions, 2007 to June 2012**

[X]

Source: Ramsay.

- 3.34 Table 3.5 provides a summary of the financial performance of Ramsay between January 2007 and June 2012.



TABLE 3.5 Ramsay summary financial information

	£'000				
	FY08*	FY09	FY10	FY11	FY12
Insured patients	[X]	[X]	[X]	[X]	[X]
Self-pay patients	[X]	[X]	[X]	[X]	[X]
NHS patients	[X]	[X]	[X]	[X]	[X]
Outpatient	[X]	[X]	[X]	[X]	[X]
Other	[X]	[X]	[X]	[X]	[X]
Total revenue	[X]	[X]	[X]	[X]	[X]
Gross profit	[X]	[X]	[X]	[X]	[X]
EBITDA	[X]	[X]	[X]	[X]	[X]

Source: Ramsay.

[X]

## Other private hospitals and private hospital operators

### The London Clinic

- 3.35 The London Clinic opened in 1932 and was granted charitable status in 1935. Its current facilities are located in and around Harley Street in central London and comprise 74 consulting rooms, 13 operating theatres, a level 3 intensive care unit, 181 overnight beds and 59 day-beds. TLC, which describes itself as the largest 'independent'<sup>100</sup> private hospital in London, admitted slightly fewer than 22,000 patients in 2011.<sup>101</sup> It focuses on high-acuity treatments and provides most of the major clinical specialties with the exception of cardiac surgery, obstetrics and psychiatry. In 2009, TLC opened its Cancer Centre adjacent to its main clinic in Devonshire Place.
- 3.36 As a charity, TLC is governed by a Chairman and Board of Trustees, with all surpluses reinvested into the hospital and, like other charities, may benefit from certain tax relief and exemptions.<sup>102</sup>
- 3.37 The turnover of TLC grew from £[X] in 2006 to £[X] in 2011, an average annual growth rate of [X] per cent (see Table 3.6). Over the same period, [X] increased from £[X] to just over £[X], with margins remaining constant at [X] per cent. TLC's revenue is generated largely from insured patients, who account for around [X] per cent of the total. The remaining [X] per cent of its revenue is split evenly between self-pay and international patients, with almost no revenue generated from NHS patients.

<sup>100</sup> In the sense that it is independent of the main hospital groups (BMI, HCA, Nuffield, Ramsay and Spire).

<sup>101</sup> Admissions figures do not include outpatient consultations. In 2011, TLC held just under 110,000 outpatient consultations.

<sup>102</sup> See [www.hmrc.gov.uk/charities/tax/basics.htm](http://www.hmrc.gov.uk/charities/tax/basics.htm).

TABLE 3.6 **TLC summary financial information**

	£'000				
	FY07	FY08	FY09	FY10	FY11
Insured patients	[X]	[X]	[X]	[X]	[X]
Self-pay patients	[X]	[X]	[X]	[X]	[X]
Overseas patients	[X]	[X]	[X]	[X]	[X]
Other	[X]	[X]	[X]	[X]	[X]
Total revenue	[X]	[X]	[X]	[X]	[X]
Gross profit	[X]	[X]	[X]	[X]	[X]
EBITDA	[X]	[X]	[X]	[X]	[X]

Source: TLC.

### *Bupa Cromwell Hospital*

- 3.38 Bupa, which had previously sold all of its hospitals, acquired the Cromwell hospital in 2008. The 131-bed hospital is located on Cromwell Road in Kensington and provides care across more than 50 subspecialties with a particular focus on [X].
- 3.39 The hospital has five operating theatres and 29 consulting rooms. In 2011, Bupa Cromwell Hospital (BCH) generated £[X] in revenues and £[X] (see Table 3.7). Revenues were split between insured patients ([X] per cent), overseas patients ([X] per cent), self-pay patients ([X] per cent) and NHS-funded patients ([X] per cent).

TABLE 3.7 **BCH summary financial information**

	£'000			
	FY08	FY09	FY10	FY11
Total revenue	[X]	[X]	[X]	[X]
EBITDA	[X]	[X]	[X]	[X]

Source: BCH.

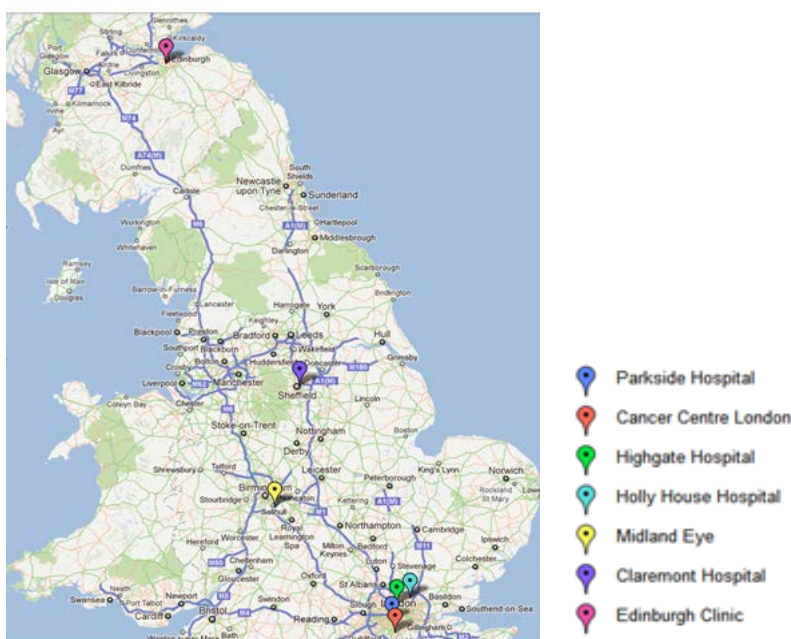
### *Aspen*

- 3.40 Aspen Healthcare has eight facilities in the UK, five of which are based in and around London, with one each in Sheffield, Edinburgh and Solihull (see Figure 3.11). These vary in size from a full-service hospital with a high dependency unit and dedicated cancer centre (Parkside) to consulting rooms that offer day-patient and minimally invasive procedures (Chelmsford Medical Centre). In total, Aspen's hospitals contain 16 theatres, 81 consulting rooms, 191 overnight beds and 34 day-beds. In the financial year ended 31 December 2011, the business generated £[X] of revenue and £[X] (excluding General and Administrative (G&A)).



FIGURE 3.11

### Location of Aspen's hospitals and clinics



Source: Aspen.

Note: In addition to the locations shown, Aspen also has a facility in Chelmsford.

- 3.41 Aspen is currently owned by Welsh Carson Anderson and Stowe (a US-based private equity house), having been originally formed in 1998 via a management buyout of Paracelsus UK from Paracelsus Kliniken Deutschland GmbH. At the time of the transaction, Aspen owned the Parkside and Holly House hospitals. In 2003, the business completed the construction of Cancer Centre London, and acquired the Highgate Hospital, followed in 2011 and 2012 by the acquisition of The Edinburgh Clinic, The Claremont (Sheffield), the Midland Eye Clinic and The Chelmsford Private Day Surgery Hospital.<sup>103</sup>
- 3.42 Aspen pursues a flexible expansion strategy, acquiring both full-service hospitals and Ambulatory Surgical Centres (ASCs), depending on the characteristics of the local market and the opportunities that arise.<sup>104</sup> Aspen also told us that it operated a number of equity-based JVs with consultants.
- 3.43 Table 3.8 provides a summary of the financial performance of Aspen between 2007 and 2011.

<sup>103</sup> Aspen [website](#).

<sup>104</sup> ASCs provide a range of diagnostic testing as well as day-patient surgery and medical treatments but not inpatient services.

TABLE 3.8 Aspen summary financial information

	£'000				
	FY07	FY08	FY09	FY10	FY11
Total revenue	[X]	[X]	[X]	[X]	[X]
EBITDA (excl G&A)	[X]	[X]	[X]	[X]	[X]

Source: Aspen.

## Circle

- 3.44 Circle, was set up in 2004, originally as Centres of Clinical Excellence. The feature that distinguished its business model from other private hospital operators' was that, in return for committing to undertake a certain proportion of their work at a Circle facility, consultants would be entitled to an equity stake in the business. Circle told us that 1,200 consultants had entered into contractual commitments with it.
- 3.45 Circle's strategy was to provide healthcare to both private and NHS patients from its facilities, the latter arising from what it saw as the growing demand for independently-provided healthcare services created by NHS reforms.
- 3.46 Circle's first acquisition was made in 2007, when it bought Nations Healthcare, an operator of three NHS ISTCs in Bradford, Burton and Nottingham. Two of these contracts have now expired, with the Nottingham facility still operated by Circle.<sup>105</sup> In addition to its NHS-focused activities, Circle opened its first private hospital in Bath in March 2010, followed by its Reading hospital in August 2012. At the current time, Circle is seeking to secure sufficient consultant commitments and raise financing for a third private hospital in Manchester.
- 3.47 Circle's business model relies on consultants committing to undertake a proportion of their work at a Circle facility in exchange for a small equity stake in the Circle Partnership.<sup>106</sup> The commitment by consultants is time-limited to two years following a hospital's opening. At present, all consultants practising at a Circle hospital have met this time limit requirement and therefore are able to terminate their obligation if they so choose.<sup>107</sup>
- 3.48 Table 3.9 provides a summary of financial information of Circle between 2009 and 2012.

<sup>105</sup> AIM Admission Document June 2011, p47.

<sup>106</sup> Circle is currently in a corporate restructuring process which will result in Circle Health Limited becoming a 100 per cent subsidiary of Circle Holdings plc. The current proposal is that clinicians and employees who previously owned shares in Circle Partnership will instead be granted shares or, in future, options over shares in Circle Holdings plc.

<sup>107</sup> All other consultants who have been signed up for future Circle facilities may also terminate their obligation if they so choose.

TABLE 3.9 Circle summary financial information

	£'000			
	FY09	FY10	FY11	FY12
Revenue	[X]	[X]	[X]	[X]
Gross profit	[X]	[X]	[X]	[X]
Operating profit	[X]	[X]	[X]	[X]

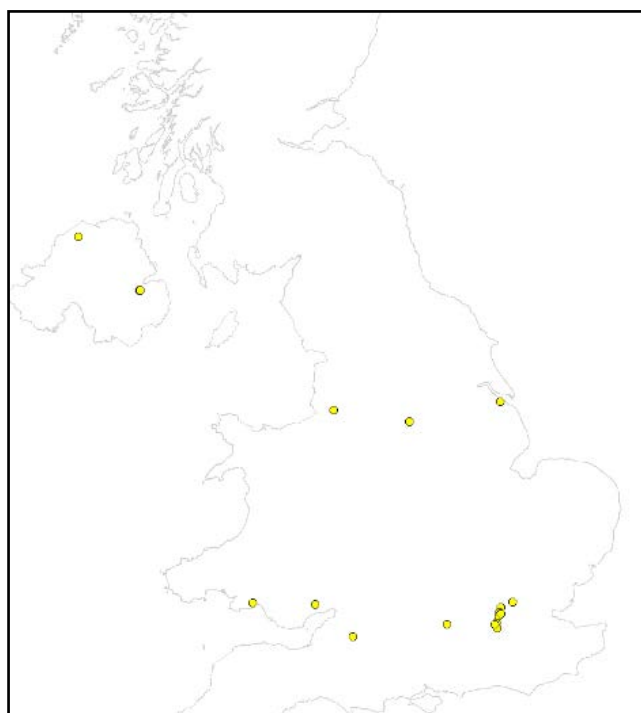
Source: Circle Holdings plc.

### Independent hospitals

- 3.49 On top of the main hospital groups, other private hospital providers and larger private hospitals, there are a number of smaller, independent private hospitals in the UK. These are often operated as (religious) charities and are located throughout the country, with a concentration in London (see Figure 3.12).

FIGURE 3.12

#### Location of independent hospitals



Source: CC analysis.

Note: This map includes Circle, TLC and BCH.

### NHS Private Patient Units

- 3.50 In addition to the private hospital operators, the NHS also provides private healthcare services to patients via PPUs.<sup>108</sup> There are 83 PPUs in the UK,<sup>109</sup> with a total of 1,152 dedicated beds and approximately 1,500 non-dedicated beds, which are used to treat private patients on an irregular basis, which have historically had a private

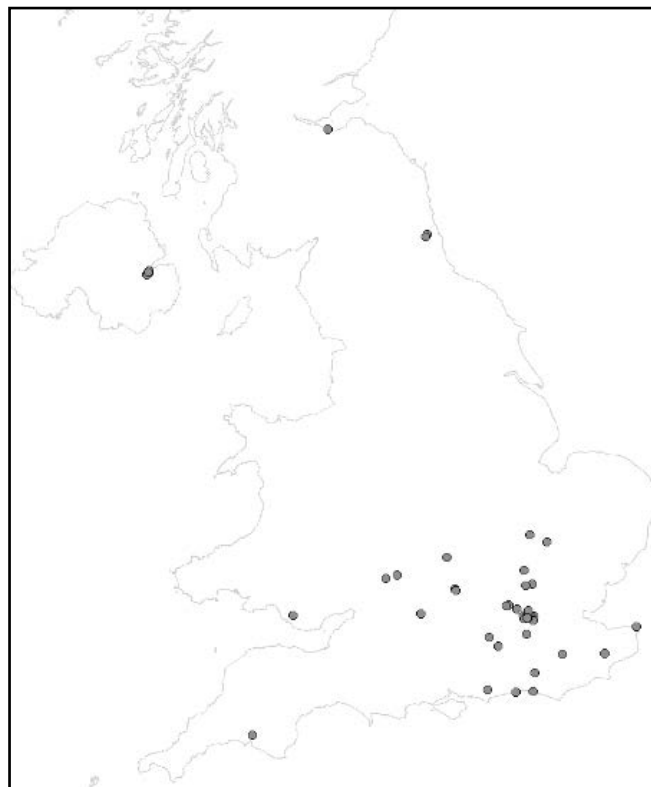
<sup>108</sup> For information on the impact of PPU expansion following the lifting of the private patient income cap, see Appendix 3.1.

<sup>109</sup> Laing & Buisson Private Acute Medical Care 2013, p98.

patient occupancy rate of about 10 per cent (see Figure 3.13).<sup>110</sup> The largest and most active PPUs are generally attached to teaching hospitals and located in London and the South-East.

FIGURE 3.13

**Location of PPUs**



Source: CC analysis.

- 3.51 Table 3.10 shows the total revenue earned by PPUs in 2011/12 and 2012/13, together with their share of the total. None of the top ten PPUs are located outside London. Many of the largest PPUs specialize in certain types of treatment rather than offering a broad range of healthcare services. For example, the Royal Marsden specializes in the treatment of cancer and Great Ormond Street focuses on paediatrics.
- 3.52 The revenue of the largest PPUs increased by 12.1 per cent between 2011/12 and 2012/13, while the smaller PPUs saw their revenues fall by 2.3 per cent.<sup>111</sup>

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<sup>110</sup> *ibid*, p98.

<sup>111</sup> *ibid*, p97.

TABLE 3.10 Revenue of NHS PPUs

	£ million		
	2011/12	2012/13	% share NHS PP revenue
Royal Marsden FT	51.1	59.8	11.9
Great Ormond Street FT	28.2	41.3	8.2
Imperial College Healthcare	28.6	30.5	6.0
Royal Brompton & Harefield FT	29.1	28.8	5.7
Royal Free Hampstead	21.2	21.8	4.3
Moorfields Eye Hospital FT	19.2	19.2	3.8
University College London FT	13.4	18.3	3.6
Guy's & St Thomas'	21.2	17.7	3.5
King's College Hospital FT	10.7	13.2	2.6
Chelsea & Westminster FT	10.5	10.9	2.2
<b>Top 10 Trusts</b>	<b>233.2</b>	<b>261.5</b>	<b>51.8</b>
Other Trusts	248.9	242.9	48.2
Total NHS	482.1	504.4	100.0

Source: Laing & Buisson Private Acute Medical Care 2013 Table 4.2.

## Clinicians

### Overview

- 3.53 In the UK, the term 'doctor' is used to refer to a wide range of medical practitioners including GPs, consultants (specialists), specialty doctors (previously referred to as staff and associate specialist doctors, foundation doctors, specialty (including GP) post-graduate doctors in training, and doctors not entered on the specialist register).<sup>112</sup>
- 3.54 As at 31 December 2012, there were approximately 236,000 licensed doctors<sup>113</sup> on the GMC's medical register<sup>114</sup> in the UK. Of these, approximately 73,000 were on the GMC's Specialist Register and 61,000 were on the GP Register.<sup>115</sup> Both the number of consultants and the number of GPs have been increasing since 2003: the number of GPs grew by 16 per cent between 2003 and 2012 (though between 2011 and 2012, there was a 0.1 per cent decline) and the number of consultants grew by 41 per cent in the same period (3 per cent between 2011 and 2012).<sup>116</sup> However, the BMA suggested that the proportion of consultants who practise privately has been in decline in recent years, and has estimated that fewer than 10 per cent of new consultants practise privately.<sup>117</sup> The BMA estimated that in 2005, 59 per cent of NHS Consultants were also practising in the private sector. By 2006 the National Audit Office put the figure at 55 per cent of the total workforce.<sup>118</sup> This suggests that growth in the population of consultants practising privately in the last ten years is

<sup>112</sup> The state of medical education and practice in the UK 2013 (TSMEP 2013) p17: [www.gmc-uk.org/SOME2013\\_web.pdf\\_53703867.pdf](http://www.gmc-uk.org/SOME2013_web.pdf_53703867.pdf).

<sup>113</sup> *ibid*, p17.

<sup>114</sup> In addition, there is a GP Register and a Specialist Register on which GPs and consultants, respectively, must also be registered.

<sup>115</sup> TSMEP 2013, p17. Bupa estimated that it recognized approximately 22,000 consultants in private practice.

<sup>116</sup> <http://bma.org.uk/working-for-change/nhs-watch/nhs-watch-how-many-doctors-work-in-the-uk> (accessed 11 February 2014) In England, these figures are slightly higher, with the average annual increase of FTE consultants at 4.4 per cent and the average annual increase of FTE GPs at 2.1 per cent (*NHS Workforce: Summary of Staff in the NHS: Results from September 2012 Census*:

<https://catalogue.ic.nhs.uk/publications/workforce/numbers/nhs-staf-2002-2012-gene-prac/nhs-staf-2002-2012-over-rep.pdf>, p6)

<sup>117</sup> Lang & Buisson Private Acute Medical Care 2013, p144.

<sup>118</sup> Program of Research Exploring Issues of Private Healthcare Among General Practitioners and Medical Consultants. (Program of Research), [www.off.gov.uk/shared\\_off/market-studies/Population-Overview-Report-1.pdf](http://www.off.gov.uk/shared_off/market-studies/Population-Overview-Report-1.pdf).

probably more modest than the overall growth rate for consultants,<sup>119</sup> a result of the narrowing of the gap in earnings between private practice and the NHS.

- 3.55 For the purpose of the market referred to us, we have concentrated on GPs and consultants, as their practices are most relevant to the issues considered in this investigation.

### *Associated organizations*

- 3.56 In Section 2, we describe the regulatory regime for private healthcare, including how doctors are regulated in the UK—we complement that information here.
- 3.57 The GMC ensures proper standards in the practice of medicine (see paragraph 2.75), and has four mandated functions under the Medical Act 1983:
- (a) keeping up-to-date registers of qualified doctors;
  - (b) fostering good medical practice;
  - (c) promoting high standards of medical education and training; and
  - (d) dealing firmly and fairly with doctors whose fitness to practise is in doubt.
- 3.58 In order to practise medicine in the UK, doctors must be both registered with and licensed by the GMC.<sup>120</sup> The medical royal colleges are charged with setting standards within their field and for supervising the training of doctors within their specialties, but ultimate responsibility for ensuring that those standards are applied rests with the GMC.
- 3.59 The BMA is the trade union and professional association for doctors in the UK. As a trade union, it provides individual and collective representation to the country's doctors, and as a professional association, it leads debate on key ethical, scientific and public health matters through research and publication.<sup>121</sup>
- 3.60 The Health and Social Care Act 2008 requires providers of regulated activities, which includes consultants, to be registered with the CQC.<sup>122</sup> However, a consultant with practising privileges is deemed to be an employee of the relevant facility and will benefit from that facility's registration. A consultant who sets up their own clinic or consulting rooms either alone or with other consultants or who otherwise does not have practising privileges will need to be registered.

### *GPs*

- 3.61 The services provided by GPs are defined under the General Medical Services (GMS) contract,<sup>123</sup> and fall into three different categories: essential, additional and enhanced. Essential services are those for patients who have acute, chronic or terminal illnesses or conditions. GP practices are expected (but not required) to provide additional services, such as minor surgery procedures or maternity services. Enhanced services are those essential or additional services that are delivered to a

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<sup>119</sup> Laing & Buisson Private Acute Medical Care 2013, p144.

<sup>120</sup> See paragraphs 2.75–2.78.

<sup>121</sup> <http://bma.org.uk/about-the-bma/what-we-do>.

<sup>122</sup> The sections of this Act that relate to the CQC are applicable in England and Wales.

<sup>123</sup> The GMS is a UK-wide contract governing the relationship between general practices and primary care organizations for delivering primary care services to local communities.

higher standard, or more specialized services. They are commissioned and developed either under national direction with national specifications and benchmark pricing to cover the relevant patient population or locally.<sup>124</sup>

- 3.62 GPs also provide a link to further health services and work closely with other health-care colleagues, developing those services and arranging hospital admissions and referrals to consultants.
- 3.63 All doctors working in general practice in the health service in the UK<sup>125</sup> are required to be included on the GP Register. While a significant amount of data is available about GPs practicing in the NHS, the same breadth and amount of data is not available with regard to private sector GPs. However, the information that is available suggests that the 'private GP workforce is very small, since in 2009 just 3 per cent of total GP consultations were carried out privately'.<sup>126</sup>
- 3.64 There are some differences across the UK in the oversight and delivery of GP services. In England, NHS England is responsible for the planning and delivery of primary healthcare services. Primary care services are managed by 14 regional health boards in Scotland and coordinated by seven health boards in Wales which provide information about local GP services. In Northern Ireland, there is one Health and Social Care Board which is responsible for the overall management of local health services.<sup>127</sup>

### *Consultants*

- 3.65 Consultants accept ultimate responsibility for the care of patients referred to them, and therefore are in a position of considerable responsibility.<sup>128</sup> This is especially the case in private practice: 'when a surgeon has patients under their care within the NHS, the patients tend to be looked after by a large team, including a variety of grades of trainees. Care in the private sector is generally delivered entirely by the consultant'.<sup>129</sup>
- 3.66 A consultant typically works in a hospital, where their primary duty is to establish a diagnosis, and then to give advice and provide treatment where appropriate. Consultants are also involved in and lead multidisciplinary teams. The aim is to deliver joined-up care by taking a comprehensive view of the care pathway, and managing other team members (eg nurses, anaesthetists, physiotherapists, pharmacists etc) accordingly. Another important aspect of the consultant's role is to be involved in teaching and training students and junior doctors, and to contribute research to their field of specialty through research.<sup>130</sup>
- 3.67 A consultant is a senior doctor who practises in one of the medical specialties. There are 65 such specialties. Each specialty has its own college or faculty that sets standards and all consultants have to be a member of a relevant college or faculty to be able to practise. Consultants undergo the same basic training as other doctors in general medicine and surgery with additional training and experience in their relevant specialism. It takes approximately ten years to qualify as a consultant. Key specialties include:

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<sup>124</sup> The New General Medical Services contract: [www.nhsemployers.org/SiteCollectionDocuments/gms\\_contract\\_cd\\_130209.pdf](http://www.nhsemployers.org/SiteCollectionDocuments/gms_contract_cd_130209.pdf).

<sup>125</sup> Other than doctors in training such as GP Registrars (TSMEP 2012).

<sup>126</sup> Program of Research, p16.

<sup>127</sup> *It's Your Practice: A patient guide to GP services*.

<sup>128</sup> [www.rcplondon.ac.uk/medical-careers/consultant-physicians](http://www.rcplondon.ac.uk/medical-careers/consultant-physicians).

<sup>129</sup> <http://surgicalcareers.rcseng.ac.uk/surgeons/practising-as-a-surgeon/independent-practice>.

<sup>130</sup> [www.rcplondon.ac.uk/medical-careers/consultant-physicians](http://www.rcplondon.ac.uk/medical-careers/consultant-physicians).

- (a) obstetrics and gynaecology: female reproductive conditions including pregnancy;
- (b) general surgery: treatment of conditions by internal operation;
- (c) trauma and orthopaedics: injuries to the musculoskeletal system;
- (d) anaesthetics: the use of medicines to anaesthetize patients during surgery and medical procedures;
- (e) urology: conditions of the urinary tract and male reproductive organs;
- (f) gastroenterology: conditions of the digestive system;
- (g) ophthalmology: conditions of the eye;
- (h) otolaryngology: conditions of the ear, nose and throat;
- (i) dermatology: conditions of the skin;
- (j) plastic surgery: 'correction' or restoration of form and function;
- (k) cardiology: conditions of the heart;
- (l) general medicine: the effects of different medication including side effects and how medicines interact;
- (m) neurology: conditions of the nervous system;
- (n) oral and maxillofacial surgery: surgery to treat conditions in the head, neck, face, jaws and the hard and soft tissues of the oral and maxillofacial region;
- (o) rheumatology: conditions of the joints, soft tissues, autoimmune system, vascular system and connective tissues;
- (p) clinical radiology: the use of imaging to diagnose, treat and monitor various disease processes; and
- (q) oncology: treatment of tumours and cancer.

- 3.68 In order to establish and operate a private practice, a consultant must be fully registered and licensed by the GMC in accordance with the Medical Act 1983, approved by an Advisory Appointments Committee as part of the NHS Consultant appointment process and have medical indemnity insurance.
- 3.69 All private hospitals have Medical Advisory Committees (MACs) comprising consultants of all specialties offered at the private hospital. In order to practise at a private hospital, a consultant will require admission rights or practising privileges. The MAC will determine the standards required to be met by consultants wishing to practise as well as the clinical governance requirements whilst in practice. We looked at the requirements of the main hospital groups in terms of practising privileges. These are relatively standard and cover eligibility, confidentiality and legislative requirements, scope of procedures, review and suspension of practising privileges and rights of appeal, and document management, among other things.
- 3.70 To treat insured patients, a consultant will need to register with a PMI. In order to do so, the PMI may request copies of documents that will satisfy it that the consultant is suitably qualified to provide medical care to their customers.



- 3.71 A consultant in private practice will also require indemnity insurance. Consultants practising in the NHS benefit from the NHS Indemnity, under which NHS bodies take direct responsibility for costs and damages arising from clinical negligence of their employees including consultants. Consultants practising both in the NHS and privately must be aware of work which does not fall strictly within their NHS contract, as it is not covered by the NHS Indemnity, and must decide what separate indemnity cover they need for any work they undertake outside their NHS contract. The most common way of securing indemnity insurance is through membership of one of the three medical defence organizations.<sup>131</sup>

### ***PMI—products and providers***

- 3.72 Below we describe the background to the PMI industry in so far as it relates to private healthcare. We also examine the individual providers, their business strategies and their products.

#### ***Background***

- 3.73 There were almost 6.9 million<sup>132</sup> company-paid and individual-paid subscribers to PMI in the UK at the end of 2012, though there are marked regional and socio-economic variations in penetration.
- 3.74 Estimates put average UK PMI penetration at 10.8 per cent at the end of 2012.<sup>133</sup> The available regional information (which, unfortunately, dates from 2006 so is not very recent) shows that penetration ranged from almost 18 per cent in London to 8 per cent or less in the North-East and Northern Ireland.<sup>134</sup> Since the areas of highest PMI penetration are also some of the most densely populated parts of the UK, the absolute numbers of people with PMI cover are highest in London and the South-East, and we have no reason to believe that relative rates of penetration across the UK have changed significantly.
- 3.75 The majority of people with private health cover receive it as an employee benefit. Approximately 5.3 million people are covered under an employer's scheme compared with about 1.5 million who subscribe individually.<sup>135</sup> Since 2008, the number of people covered by their employer's scheme has been falling. This has also been the case for the number with individual cover since the mid-1990s.<sup>136</sup>
- 3.76 An employer wishing to provide its employees with private medical cover can choose to be fully insured, in effect paying a premium to the PMI in respect of its employees or—and more commonly for large companies—it can establish a self-insured scheme.<sup>137</sup> Typically this will involve setting up a trust to fund claims and appointing a third party, usually a PMI, to administer the process, including claims handling. SMEs are more likely to be fully insured.
- 3.77 The PMIs differ in the amount of individual, large corporate (trust or otherwise) and SME business they undertake. We show in Figure 3.14 the lives each covers in the various categories of scheme.

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<sup>131</sup> Medical Defence Union, Medical Protection Society and the Medical and Dental Defence Union of Scotland.

<sup>132</sup> Laing & Buisson Health Cover 2013, p15.

<sup>133</sup> *ibid*, p15.

<sup>134</sup> *ibid*, p17.

<sup>135</sup> *ibid*, p16.

<sup>136</sup> *ibid*, p16.

<sup>137</sup> One advantage of doing so is that the firm does not need to pay Insurance Premium Tax, currently levied at the rate of 6 per cent.

FIGURE 3.14

### Lives covered by PMI and by category, 2011



Source: Bupa, AXA PPP, Aviva and PruHealth.

#### *The cost of private medical cover*

- 3.78 The cost of private medical cover has been rising for both individual subscribers and corporate clients. The average price per individual subscriber paid for private medical cover more than doubled between 1995 and 2012, increasing by over 60 per cent in real terms.<sup>138</sup>
- 3.79 The cost of private healthcare to employers has also risen over the same period, though at a slower rate than for individual subscribers. The average price per life covered doubled in nominal terms and rose by about a third in real terms.<sup>139</sup>

#### *Market shares*

- 3.80 The ranking of the largest PMIs has been relatively stable for the past 20 years.<sup>140</sup> The PMI industry is concentrated (see Figure 3.15), and the top four PMIs' share of the private health cover market reached about 87.5 per cent in 2012, with the remaining 12.5 per cent being accounted for by 12 smaller providers.<sup>141</sup> This growth has been driven more by the third- and fourth-ranked PMIs with the share of the top two rising only very slightly. The share of the third- and fourth-ranked PMIs grew from 14.5 per cent in 2000 to 22 per cent in 2012.<sup>142</sup> Major share movements have tended to be as a result of acquisition rather than organic growth.<sup>143</sup>

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<sup>138</sup> Laing & Buisson, Health Cover 2013, p25.

<sup>139</sup> *ibid*, p23. The price per life is lower for corporate clients since the cost of claims is likely to be lower due to the risk profile of the insured base. A corporate scheme will be open to low- and higher-risk members but individual subscribers are self-selecting.

<sup>140</sup> *ibid*, p127.

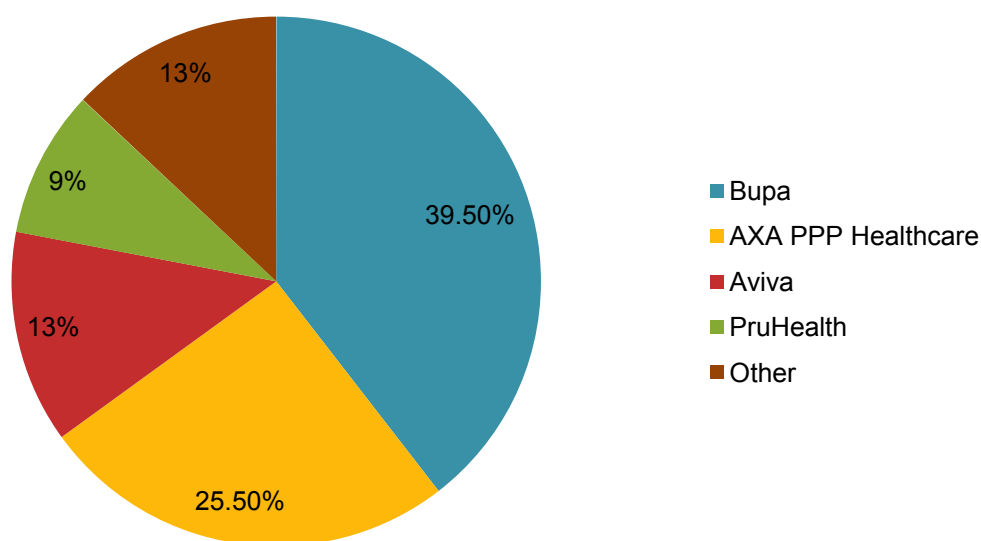
<sup>141</sup> *Ibid*, p130.

<sup>142</sup> *ibid*, p130, figure 7.2.

<sup>143</sup> See the descriptions of the individual providers below for examples of acquisitions.

FIGURE 3.15

### PMI market share by revenue, 2012



Source: Laing & Buisson, Health Cover 2013.

#### PMI products

- 3.81 PMI offers the same kinds of benefits as do other forms of general insurance: the policy pays out if the event insured against occurs. In the case of PMI, the risk being insured against is an acute illness or condition.
- 3.82 The cost of the premium will vary with the coverage and benefits provided, for example the range of hospitals the insured may use in the event of a claim, and with the likelihood and probable cost of a claim. The likelihood of a claim will vary in particular with the age<sup>144</sup> and lifestyle of the individual policyholder and the cost of claims may vary with the geographical location of the insured.
- 3.83 As with other forms of general insurance, policyholders can reduce the level of premium by accepting some of the risk themselves, say the first £250 of a claim. This amount is known as the policy 'excess'.<sup>145</sup>
- 3.84 One important difference between PMI and other types of general insurance is that the individual may already be suffering from a condition, or may have done so in the recent past, when they take out a policy. In these circumstances insurers will, through a process known as 'full medical underwriting', ask the prospective policyholder for details of their medical history and will specify on their insurance certificate what conditions are excluded from cover. Alternatively, the insurer may offer 'moratorium underwriting' as an option. In this case, the prospective policyholder will

<sup>144</sup> The premium for a 70 year old is typically at least three times that of a 35 year old. See <http://www.which.co.uk/money/insurance/guides/choosing-private-medical-insurance/pmi-policies-compared/> (Accessed November 2012).

<sup>145</sup> In 2010, PruHealth offered its subscribers another way to reduce the level of their premiums through 'co-insurance' with its Value product in 2010. This required the policyholder to make a co-payment in the event of a claim, for example £100 for each inpatient admission. This product was bought by around 160 customers only over three years.

not be asked to provide their medical history but any pre-existing conditions that they have received treatment or medication for, received advice about or experienced symptoms of within a specified time period will automatically be excluded. Moratorium underwriting is normally cheaper, though offers less certainty to the policyholder as to what exactly is covered and what is excluded.

- 3.85 Other exclusions from cover will, in all cases, be long-term, chronic conditions and, in most cases, policies will exclude cover for accident and emergency treatment, drug abuse, HIV/AIDS, normal pregnancy and injuries incurred from participation in dangerous sports or hobbies ('hazardous pursuits').
- 3.86 PMI differs from health cash plans in that the latter are intended to help cover the cost of everyday healthcare such as visits to the optician or the dentist<sup>146</sup> rather than, as in the case of PMI, the whole of the cost of hospital treatment. Some PMIs, however, will offer subscribers the option of taking a cash payment if they elect to be treated on the NHS rather than at a private hospital. Bupa, for example, provides a cash payment option for subscribers who choose to have an NHS knee replacement.<sup>147</sup>

### *PMI business models*

- 3.87 The current PMI businesses originated in two different ways. Some, like Bupa and WPA, grew out of provident associations, established specifically to provide healthcare for members. Other PMIs, like AXA PPP, Aviva and PruHealth, are part of larger insurance businesses whose parent or associated companies offer a range of insurance and other financial services products.<sup>148</sup>
- 3.88 These differences in origin may have a bearing on or place restrictions on how they do business. Aviva, for example, has been able to make discounts on its motors, home and travel insurance products available to members of some of its corporate health cover schemes which the former provident associations could not.<sup>149</sup>

### *PMI practice on patient guidance*

- 3.89 The extent to which PMIs seek to 'guide' patients to particular hospitals, consultants and care pathways is a relevant consideration for our investigation into the private healthcare market. PMIs use these open referrals to avoid customer shortfalls and to control costs (see, for example, paragraphs 7.82 to 7.92).
- 3.90 All the major PMIs offer products which are differentiated by the range of hospitals they permit policyholders day patient and inpatient access to. Typically, the PMI will offer a 'value' product with access to certain private hospitals and PPUs but not the most expensive ones which will only be available to policyholders opting for the 'premium' product, possibly with a mid-level product to complete the range.<sup>150</sup> For example, PruHealth used to offer a 'guided options' list of hospitals, for both individual and corporate customers. Policyholders who took this up must ask their GP for a guided referral letter and provide this to PruHealth which will contact the nearest appropriate hospital on the list. The hospital will then refer the patient to an appropriate consultant.

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<sup>146</sup> See the ABI guide to [health cash plans](#).

<sup>147</sup> See Bupa website, [knee replacement](#).

<sup>148</sup> The PMIs that are part of insurance businesses generally go beyond just indemnifying risk. All the larger ones offer 'well-being' information, advice and, in the case of [PruHealth](#), rewards for adopting a healthier lifestyle.

<sup>149</sup> See Aviva [website](#).

<sup>150</sup> See, for example, the [WPA Premium hospital list](#) or Simplyhealth's [hospital directory](#).

- 3.91 PMIs differ in the degree to which they guide patients towards particular consultants. All four of the largest PMIs (Bupa, AXA PPP, PruHealth and, very recently, Aviva) have adopted or expanded processes for some of their subscribers which guide them to 'approved' or 'recognized' consultants.<sup>151</sup>
- 3.92 For example, Bupa's Open Referral process, which is mandatory for members of some of its corporate schemes and an option for individual subscribers, requires the patient's GP to make a referral not to a specific, named consultant but to a consultant with the particular specialism suggested as appropriate by the GP's initial diagnosis. Bupa advisers will then recommend one of their recognized, fee-assured consultants (ie consultants who have agreed to work within Bupa's fee maxima).
- 3.93 AXA PPP similarly provides guidance to patients whose employers have adopted its Healthcare Pathway product,<sup>152</sup> as has Aviva, which has recently launched a new product called GuideWell for large corporate customers.<sup>153</sup>
- 3.94 PruHealth claims to be the only PMI to offer a 'full refund' policy and does not decline to recognize consultants on the basis of their fees. It recognizes all consultants who are registered with the GMC, hold a licence to practise and who are on the Specialist register.<sup>154</sup> It publishes what it considers are 'customary and reasonable' rates, which it derived from a benchmarking operation in 2011. PruHealth's website warns consultants that fees that fall outside this guidance may be challenged and that consultants who persistently bill outside of its guidelines face derecognition.<sup>155</sup>
- 3.95 PMIs offering these options may also employ processes to guide patients towards particular healthcare pathways. Aviva, for example, offers its BacktoBetter service for musculoskeletal conditions, providing an alternative clinically case-managed approach to the traditional GP to consultant referral pathway. Bupa offers direct access to its Back Care service as an alternative to visiting a GP.<sup>156</sup>

## *Bupa*

- 3.96 In 1947, 17 provident associations amalgamated to form the British United Provident Association. We have received submissions about Bupa's status. Bupa is a company limited by guarantee with no shareholders. It is now the largest of the PMIs with a market share of 39.5 per cent by revenue in 2012 and UK revenues of around £1.5 billion. It confines its activities to the healthcare sector, though not necessarily to health insurance: for example, it has expanded into healthcare provision, acquiring care homes and dental practices and moving back, at least to a limited extent, into running acute hospitals.<sup>157</sup>
- 3.97 Like other PMIs, Bupa provides services to individual PMI subscribers and to employers. Figure 3.14 shows the proportion of lives covered by Bupa in these different segments.
- 3.98 Bupa for You is Bupa's individual PMI cover, which is customized by the subscriber's choice of core health insurance options, hospital network and additional healthcare options. Bupa also has Bupa Health Solutions for corporates, offering SMEs flexible

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<sup>151</sup> See paragraphs 7.82 to 7.92.

<sup>152</sup> [Healthcare Pathway](#). Patients will be referred via their consultant for treatment at one of the hospitals on a list which, among others, includes TLC, and some or all of BMI, Nuffield, Aspen and Spire hospitals.

<sup>153</sup> [GuideWell](#).

<sup>154</sup> See PruHealth [website](#).

<sup>155</sup> See PruHealth [website](#).

<sup>156</sup> [Bupa back care](#).

<sup>157</sup> Bupa acquired the Cromwell Hospital in 2008.

coverage through its Foundation (working in conjunction with the NHS), Select (most comprehensive cover offering three different tiers: key, enhanced and complete) and Superior (geared towards executives) products, and bespoke coverage for larger businesses. Bupa's Open Referral is the default option for corporate customers, guiding patients to consultants who have agreed to charge within Bupa's fee structure.

- 3.99 Table 3.11 shows Bupa's financial performance between 2004 and 2011. Between FY08 and FY10, Bupa was significantly affected by a combination of declining numbers of policyholders and continued growth in claims costs.

TABLE 3.11 Bupa summary financial information

	£ million							
	FY04	FY05	FY06	FY07	FY08	FY09	FY10	FY11
Total income	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Net claims	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Loss ratio (%)	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Underwriting expenses	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Underwriting result	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Combined ratio (%)	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]

Source: Bupa.

## AXA PPP

- 3.100 AXA PPP is the second largest PMI in the UK, with a market share of around 25.5 per cent and revenue of £981 million.<sup>158</sup> The original Private Patient Plan business was acquired by Guardian Royal Exchange in 1998 which was itself acquired by Sun Life, part of the AXA insurance group, the following year. To reflect this change of ownership, the business was subsequently renamed AXA PPP healthcare. AXA PPP bought the Legal & General medical cover business in 2007.
- 3.101 The relative size of AXA PPP's customer segments is shown in Figure 3.14. AXA PPP's Health Select product offers core cover to individual PMI subscribers, with up to nine different add-on options, ranging from extra outpatient cover to dentist and optician cash-back. The Business Health Select product covers SMEs, and offers tailored options which can be enhanced with different add-ons similar to those for individuals. For corporate clients, AXA PPP offers the Corporate Health Plan (which leaves the choice of hospital and consultant to the member and the GP), the Corporate Health Plan Plus (which leaves the choice of hospital and consultant to the member, and the GP and does not have any cap on consultant fees) and the Healthcare Pathway (which uses guided referral, guiding members to its list of consultants and hospitals for treatment).
- 3.102 Table 3.12 shows AXA PPP's financial performance between FY04 and FY11.

<sup>158</sup> Estimated revenue as set out in Laing & Buisson Health Cover 2013, p126.

TABLE 3.12 AXA PPP summary financial information

	£ million							
	FY04	FY05	FY06	FY07	FY08	FY09	FY10	FY11
Total income	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Net claims	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Loss ratio (%)	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Underwriting expenses	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Underwriting result	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Combined ratio (%)	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]

Source: AXA PPP.

## Aviva Health

3.103 With a current market share of 13 per cent and UK revenues of £504 million, Aviva Health is the third largest PMI in the UK and is part of the Aviva group providing life insurance, general insurance and investment management services.

3.104 Aviva offers subscribers a range of policy options. Its Healthier Solutions product offers individual subscribers the choice to enhance their cover with additional health-care benefits. Its Extended list offers the most comprehensive selection of hospitals including the more expensive ones. Its more restrictive lists are its Key, Fair+Square, Trust and Signature lists. In addition, Aviva has created tailored lists for some of its corporate customers based on the location of the firms' employees.

3.105 The relative size of Aviva's customer segments is set out in Figure 3.14.

3.106 Table 3.13 shows Aviva's financial performance between FY04 and FY11. Aviva has grown its revenues by almost [X] per cent between 2004 and 2011.

TABLE 3.13 Aviva summary financial information

	£ million							
	FY04	FY05	FY06	FY07	FY08	FY09	FY10	FY11
Total income	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Net claims	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Loss ratio (%)	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Underwriting expenses	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Underwriting result	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Combined ratio (%)	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]

Source: Aviva.

## PruHealth

3.107 PruHealth, with a market share of 9 per cent and UK revenues of £336 million, is owned by Prudential and Discovery Holdings, a leading South African PMI. PruHealth acquired Standard Life Healthcare in 2010.

3.108 PruHealth offers three policy options. Its Local hospital policy now includes all of the BMI, Spire, Ramsay, Aspen and Nuffield hospitals as well as The Christie, St Anthony's and New Victoria, but excludes all central London hospitals and NHS PUs. Its Countrywide policy, in addition, includes TLC and King Edward VII Sister Agnes and some central London PUs. Its Premier hospital list includes all the HCA central London hospitals and PUs.

3.109 The relative size of PruHealth's customer segments is shown in Figure 3.14.

3.110 Table 3.14 shows PruHealth's performance between FY04 and FY12.

TABLE 3.14 PruHealth summary financial information

	£ million							
	FY04	FY05	FY06	FY07	FY08	FY09	FY10	FY12
Total income	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Net claims	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Loss ratio (%)	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Underwriting expenses*	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Underwriting result	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]
Combined ratio (%)	[X]	[X]	[X]	[X]	[X]	[X]	[X]	[X]

Source: PruHealth.

\*[X]

### Other PMI providers

3.111 There are various other smaller insurers operating in the PMI market—some of them are in fact provided by the major PMIs, such as Tesco health insurance, which is provided by AXA PPP. We briefly describe two of these smaller PMIs, Simplyhealth and WPA, below.

3.112 Simplyhealth has its roots in the cash plan sector, providing cash back for primary care activities. In 2004, it expanded into PMI, and now offers individuals different level of cover under its Simply Personal Health product: the basic Diagnosis cover, the optional Treatment cover and the Heart and Cancer cover. It also offers three different hospital networks: (1) Connections, which has the lowest costs, the fewest hospitals to choose from and operates a directed care claims process, (2) National and (3) Metropolitan, each of which are more expensive but allow greater choice of hospital. Corporate clients may build on one of two plans: Simply Employee Health (for SMEs) and Care for Corporates (100+ employees), both of which have options for reduced or enhanced benefits.<sup>159</sup>

3.113 WPA was founded as the Bristol Hospital Fund and acquired a Reading Contributory Fund to become the insurer now known as Western Provident Association. A third of WPA's business comes from each of the private client business, the SME business, and the large corporate business. Over the past ten years, WPA succeeded in earning a modest underwriting profit. WPA's Individual Health Insurance product allows private clients to choose from three different levels of cover (Essentials, Premier and Elite), each of which can be customized. Enterprise Flexible Benefits is for SMEs, and can be tailored according to customer needs; large corporate clients can build a bespoke product according to what they want. WPA also offers a risk-sharing option through its Shared Responsibility option, where a subscriber is able to reduce the cost of PMI materially by sharing the risk with the insurer ('co-insurance') and agreeing to pay a percentage of each claim, up to a limit which the customer selects.<sup>160</sup>

<sup>159</sup> [www.simplyhealth.co.uk/sh/pages/homepage.jsp](http://www.simplyhealth.co.uk/sh/pages/homepage.jsp).

<sup>160</sup> WPA Shared Responsibility.



## 4. Framework for our competitive assessment

- 4.1 In this section, we explain the framework we used for our competitive assessment of the provision and acquisition of privately funded healthcare services.
- 4.2 The CC initially published guidelines for the conduct of market investigations in June 2003.<sup>161</sup> The CC decided in early 2010 that the guidelines should be updated to capture the lessons learnt from the market investigations the CC had conducted since the market investigation regime was introduced under the Act. In April 2011, the CC undertook a public consultation on a revised draft of its guidelines for market investigations. In April 2013, the CC published its revised guidelines for market investigations.<sup>162</sup>
- 4.3 This section describes how we have used ‘theories of harm’ (ie hypotheses as to how a possible market characteristic—or characteristics—could give rise to an AEC) in structuring our investigation.

### *Theories of harm*

- 4.4 Paragraph 163 of the Guidelines explains that: ‘To provide focus and structure to its assessment of the way competition is working in a market the CC sets out one or more ‘theories of harm’. A theory of harm is a hypothesis of how harmful competitive effects may arise in a market and adversely affect customers.’ Paragraph 165 of the Guidelines continues by stating that ‘The starting point for formulating theories of harm in market investigations is the work already done by the referring body, particularly the terms of reference ... and decision documents.’
- 4.5 Building on the observations about the supply of privately-funded healthcare made by the OFT in its market study and the early submissions received following the OFT’s reference, we identified seven ToHs in our issues statement:<sup>163</sup>
- (a) ToH1: a private hospital operator may have market power with respect to patients in a particular geographic area.
  - (b) ToH2: individual consultants or consultant groups in some local areas may have market power over their patients.
  - (c) ToH3: a private hospital operator may have market power with respect to PMIs in national negotiations.<sup>164</sup>
  - (d) ToH4: a PMI may have buyer power over individual consultants.
  - (e) ToH5: there may be barriers to entry into the supply of privately-funded healthcare services as a result of: (i) national bargaining between insurers and hospital operators; (ii) the relationships between hospital operators and consultants or GPs; (iii) other barriers that make construction of new private hospitals difficult; and/or (iv) barriers into the provision of consultant services in private practice.

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<sup>161</sup> *Market Investigation References: Competition Commission Guidelines*, CC3, June 2003. An archived version is available at [http://webarchive.nationalarchives.gov.uk/20111108202701/http://www.competition-commission.org.uk/rep\\_pub/rules\\_and\\_guide/pdf/CC3.pdf](http://webarchive.nationalarchives.gov.uk/20111108202701/http://www.competition-commission.org.uk/rep_pub/rules_and_guide/pdf/CC3.pdf).

<sup>162</sup> *Guidelines for market investigations: Their role, procedures, assessment and remedies*, CC3 (revised), April 2013.

<sup>163</sup> *Issues statement*, paragraph 20.

<sup>164</sup> We have also investigated whether PMIs may have buyer power over some hospital operators in national negotiations.

- (f) ToH6: there may be information asymmetries and limited information available to patients (as well as GPs and possibly PMIs).
  - (g) ToH7: there may be vertical linkages that lead to foreclosure.
- 4.6 We used these ToHs to structure our investigation, and we reported on the progress of our investigation under each of these ToHs when we published our annotated issues statement<sup>165</sup> and subsequently our provisional findings.<sup>166</sup>
- 4.7 Competitive harm can flow from five main sources:
- (a) unilateral market power (including market concentration);
  - (b) barriers to entry and expansion;
  - (c) coordinated conduct;
  - (d) vertical relationships; and
  - (e) weak customer response.<sup>167</sup>
- 4.8 In the following paragraphs, we develop our theories and include references to relevant extracts from the Guidelines that relate to how the CC will undertake its assessments of unilateral market power, barriers to entry, weak customer response and vertical relationships.

#### *Unilateral market power including market concentration*<sup>168</sup>

- 4.9 This is particularly relevant to four of our ToHs. Under ToH1, we posit that some private hospital operators have market power within relevant local markets as a result of market concentration and barriers to entry. Such private hospital operators would have the ability to set higher prices than would otherwise be the case, or reduce the quality of other aspects of their offer, as a result of limited competition from other private hospital operators and limited threat of entry or expansion into the market by other private hospital operators. We examine these issues in Section 6.
- 4.10 Under ToH2, we identified that individual consultants and/or consultant groups in certain local areas may have market power over their patients, arising from three particular factors: (a) there may be a limited number of consultants in a particular area providing particular treatments or specialties; (b) the way in which patients are referred to consultants; and (c) joint setting of prices by some consultant groups. In relation to the last of these factors, we concentrated on anaesthetist groups, as patients generally have little input into the selection of their anaesthetist and because we received the highest number of complaints about this group of consultants. These issues are examined in Section 7.
- 4.11 Under ToH3, we considered whether private hospital operators might have market power in negotiations with PMIs over the price that PMIs pay when their insured patients are treated in a private hospital owned by a private hospital operator. In so far as a private hospital operator may derive its market power from its position in certain local areas and the scale of its collection of hospitals, we found that this

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<sup>165</sup> [Annotated issues statement](#).

<sup>166</sup> [Provisional findings report](#).

<sup>167</sup> [CC3](#), paragraph 170; paragraph 172; notes that these sources are not mutually exclusive.

<sup>168</sup> See [CC3](#), paragraphs 178-181, 185, 187-188, 192 & 198.

theory was closely linked to ToH1. A private hospital operator might have an added advantage if it owns a chain of hospitals, through leveraging its local market advantage or securing weighted average prices that would then also apply in more competitive markets. Private hospital operators' market power in negotiations with PMIs might lead to higher prices and/or more favourable contract terms for them than would otherwise be the case. However, we also considered whether private hospital operators' market power might be offset by PMIs' countervailing buyer power. PMIs might be able to exercise such power through credible threats to 'delist' certain private hospitals, or by developing mechanisms to steer patients towards particular private hospitals. We examine these issues in Section 6.

- 4.12 Under ToH4, we considered whether a PMI may have buyer power over individual consultants. Following publication of our Issues Statement, we found that some PMIs, in particular Bupa and AXA PPP, were requiring some individual consultants to agree not to charge patients more than the relevant PMI's maximum reimbursement rate as a requirement to be recognized and therefore, to treat the PMI's policyholders. We examine this issue in Section 7.

### *Barriers to entry*<sup>169</sup>

- 4.13 Our ToH5 set out that there may be barriers to entry that reduce competition either directly or by creating the conditions in which other ToHs can take effect, and that these could be classed into four different groups:
- (a) barriers to privately-funded healthcare services arising from national negotiations between insurers and private hospital operators;
  - (b) barriers to privately-funded healthcare services arising from relationships between private hospital operators and consultants or GPs;
  - (c) other barriers to privately-funded healthcare services; and
  - (d) barriers to the provision of consultant services in private practice.
- 4.14 Assuming that private hospital operators have market power in certain local areas (ToH1) and in national negotiations (ToH3), bargaining between insurers and private hospital operators may create barriers for new local entrants, and in particular, may give rise to contractual terms that prevent or disincentivize PMIs from recognizing new entrants. The private hospital operators may try and use their local market power to negotiate in respect of their hospitals in more competitive areas, and if PMIs want to be able to offer nationwide coverage, they may have to contract with most of the private hospital operators, and at least in relation to the private hospitals in areas where the private hospital operators have local market power. Private hospital operators might try and use their local market power in national negotiations to pressure PMIs into recognizing all of their hospitals and not to recognize those of new entrants.<sup>170</sup>
- 4.15 Barriers might also result from the relationships between private hospital operators, consultants and GPs in three ways: (a) due to the need of private hospital operators, on the one hand, to secure commitments from consultants in order to gain PMI recognition, and on the other hand, to guarantee enough PMI recognition to attract

<sup>169</sup> See CC3, paragraphs 206-208, 213, 214, 217-222 and 223-226.

<sup>170</sup> See CC3, especially paragraphs 227-234, which explain how the CC assesses the impact of entry barriers in the past, present and future, in order to test a ToH based on the effects on competition.

consultants to their facilities; (b) because of incentives provided by private hospital operators to consultants to work in their facilities, (and deterrents to consultants from committing to switch to new entrants); and (c) because of incentives provided by private hospital operators and consultants to GPs to refer patients. These barriers may be aggravated by ToH2, where there are limited numbers of consultants, and because of the way in which patient referrals are made.

- 4.16 When looking specifically at arrangements between hospital operators and clinicians in our annotated issues statement, we also identified a further theory of harm that such arrangements may distort competition between private hospital operators. We examine this issue in Section 8.
- 4.17 Other potential barriers might include the combination of high capital costs with high exit costs, depending on the type of facility and types of treatments provided. Construction of new facilities might also be hindered because of planning delays and/or incumbents strategically obstructing the planning regime, as well as the availability of appropriate sites.<sup>171</sup>
- 4.18 There may also be barriers to the provision of privately-funded healthcare services that may prevent new consultants from entering. This is closely tied to ToH2 to the extent that there may be shortages of consultants in some local areas. This might also be tied to ToH4 in that where PMIs may have buyer power in respect of consultants, which results in the latter's fees being too low, consultants may be further discouraged from entering. These issues are examined in Section 8. Incentives provided by hospital operators to clinicians may also operate as a barrier to entry and these are considered in Section 6.

#### *Weak customer response*<sup>172</sup>

- 4.19 Our ToH6 argues that information asymmetries and limited information available to patients (as well as to GPs and possibly also to PMIs) may distort competition to the extent that they limit the patient's ability to make an informed choice regarding an appropriate consultant and/or private hospital for treatment. In particular, it has been put to us that the market is characterized by: (a) information asymmetries, especially between patients and consultants or private hospital providers as regards the appropriateness, quality and price of various treatment options available to the patient; (b) the absence of information on the quality and performance of consultants and private hospitals in the provision of privately-funded healthcare services; and (c) the absence of easily comparable information on consultant and private hospital charges, particularly for self-pay patients.<sup>173</sup>
- 4.20 Information asymmetries may also be relevant to ToH2: to the extent that consultants may have market power over their patients, this may be reinforced by information asymmetries. These issues are examined in Section 9.
- 4.21 As noted above, in the annotated issues statement, we identified that financial and other incentives provided by private hospital operators to clinicians may exploit these information asymmetries. We subsequently also considered whether such incentives may distort competition between hospital operators. Our assessment of clinician incentives is contained in Section 8.

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<sup>171</sup> See CC3, especially paragraph 211 regarding 'natural' or 'intrinsic' barriers to entry.

<sup>172</sup> See CC3, paragraphs 296-304, 306, 311-312 and 315.

<sup>173</sup> See paragraphs 9.7–9.10 & 9.21–9.32.

- 4.22 Under ToH7, we considered the potential of vertical integration to adversely affect competition. We did not receive evidence of Bupa's vertical linkages through its ownership of the Bupa Cromwell Hospital or any other insurers which might own primary care facilities being likely to lead to significant harm to competition. In the annotated issues statement, we expressed concern that the ownership by private hospital groups of primary care and outpatient diagnostic centres might lead to patient referrals being predominantly made to hospitals in the same group or to over-servicing (eg additional tests). The former could, in particular, foreclose rivals from a significant proportion of rivals. This was a concern principally, but not exclusively, in central London. Our assessment of this issue is in Section 6.

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<sup>174</sup> See [CC3](#), paragraphs 267-269, 271 and 273-274.

## 5. Market definition

### *Introduction*

- 5.1 This section sets out our analysis and main findings in relation to product and geographic markets for privately-funded healthcare services.
- 5.2 The Guidelines<sup>175</sup> state that defining the relevant market enables the CC to focus on the sources of any market power and provides a framework for its assessment of the effects on competition of features of a market. In practice, the analysis of the identification of the market or markets and assessment of competitive effects largely overlaps, with many of the factors affecting market definition being relevant to the assessment of competitive effects and vice versa. Market definition is thus a useful tool, but not an end in itself, and identifying the relevant market involves an element of judgement. The boundaries of the market do not determine the outcome of the CC's competitive assessment of a market in any mechanistic way. The competitive assessment will take into account any relevant constraints from outside the market, segmentation within it, or other ways in which some constraints are more important than others.<sup>176</sup>
- 5.3 The OFT made a reference to the CC for an investigation into the supply or acquisition of private healthcare in the UK. As stated in the terms of reference,<sup>177</sup> for the purposes of this market reference, private healthcare 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.'
- 5.4 Privately-funded healthcare services consist of highly differentiated medical treatments that can be segmented, to a large extent, by type of care (ie inpatient, day case and outpatient) and by specialty (eg cardiology, orthopaedic). These services are mainly funded by patients themselves or by PMIs. We have taken these segmentations into consideration as appropriate in our analysis. In terms of (private) healthcare providers, we have considered the services provided by private healthcare facilities (including private hospitals, private day-only/outpatient clinics and NHS PPUs) and by consultants in private practice.<sup>178</sup> The results of our analysis of product and geographic markets provide a framework for the assessment of competitive constraints, in terms of the set of medical treatments and relevant (private) healthcare providers which our assessment has largely focused on.

### *Product markets*

- 5.5 The Guidelines<sup>179</sup> state that while the composition of a relevant market is usually determined by the degree of demand substitutability, the CC will where relevant include supply-side factors in defining the market. There might, for example, be a possibility that firms supplying non-substitute products have the capabilities and

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<sup>175</sup> CC3, paragraph 132.

<sup>176</sup> CC3, paragraph 133.

<sup>177</sup> Terms of reference.

<sup>178</sup> In this part of our report we have used the term 'hospital' or 'private hospital', except where the context otherwise provides, to include any private healthcare facility including a PPU providing medical treatments whether on an inpatient, day-case and/or outpatient basis. This contrasts with other parts of this report where hospital/private hospital generally refers only to facilities which provide inpatient care including PPUs and not to facilities that only provide outpatient and/or day-case care. 'Hospital services' refers to all medical treatments provided by a hospital. When appropriate, we will make a distinction between (a) hospitals which provide inpatient care and day-only/outpatient clinics which provide day-patient and/or outpatient care only; and (b) private hospitals and PPUs.

<sup>179</sup> CC3, paragraph 134.

assets to redirect production to goods and services that would be substitutes for those in the market. Alternatively, the same firms might compete to supply the non-substitute products under similar conditions of competition; in that case aggregating the supply of these products and analysing it as one market does not affect the competitive assessment (for example, in markets characterized by bidding and tendering processes).<sup>180</sup>

- 5.6 We followed this guidance in our approach to market definition. To this end, when defining the product market(s), we first looked at evidence on demand-side substitution by patients across different medical treatments and across privately-funded and NHS-funded medical treatments. We then considered whether, in the absence of demand-side substitutability across medical treatments, private healthcare providers (consultants and hospitals) have the capabilities and assets to redirect production across medical treatments (supply-side substitution). In addition, in relation to hospital services, we also considered whether the set of private healthcare providers and the conditions of competition are similar across medical treatments.
- 5.7 We considered, in particular, whether and to what extent we could aggregate treatments/cluster of treatments together on the basis of supply-side factors along the following dimensions:
  - (a) within and between specialties; and
  - (b) for a given specialty, between inpatient, day-patient and outpatient care.
- 5.8 We looked at supply-side factors for consultant and hospital services separately.

#### *Demand-side substitution by patients*

- 5.9 To assess the degree of demand-side substitution across medical treatments, we considered whether patients would switch to an alternative treatment in response to an increase in price or a decrease in quality of a given treatment. A change in quality rather than a change in price is more relevant for insured patients as, on the whole, they do not pay for specific treatments as these are covered by their medical insurance policy.
- 5.10 While patients are the final consumers of privately-funded healthcare services, they typically rely on GPs, consultants and other clinicians' advice when deciding the type of medical treatment they need.<sup>181</sup> A patients' choice of treatment is largely determined by their clinician's advice on the basis of clinical need. As a result, there is very limited scope for substitution across treatments that address different clinical needs. Even when there is some limited scope for substitution between treatments addressing the same clinical need, the final choice is likely to be mostly driven by clinical considerations.

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<sup>180</sup> The CC/OFT [Merger Assessment Guidelines \(CC2\)](#) also provide the following guidance (paragraphs 5.2.7 & 5.2.17):

(a) The relevant product market is identified primarily by considering the response of customers to an increase in the price of one of the products of the merger firms (demand-side substitution).

(b) There are circumstances where the Authorities may aggregate several narrow relevant markets into a broader one on the basis of considerations about the response of suppliers to changes in prices. They may do so when:

- (i) production assets can be used by firms to supply a range of different products that are not demand-side substitutes, and the firms have the ability and incentive quickly (generally within a year) to shift capacity between these different products depending on demand for each; and
- (ii) the same firms compete to supply these different products and the conditions of competition between the firms are the same for each product; in this case aggregating the supply of these products and analysing them as one market does not affect the Authorities' decision on the competitive effect of the merger.

<sup>181</sup> See Section 2: Industry Background on 'patient pathways'.



- 5.11 We noted that PMIs may have some ability to affect insured patients' demand for privately-funded healthcare services. First, insured patients are normally required to obtain pre-authorization from their PMI prior to seeking treatment, which means the PMI can reject the treatment if it is not covered by the patients' policy. Secondly, in some cases, PMIs can influence the choice of healthcare provider, such as their choice of consultant or hospital where they are treated. PMIs are, however, less able to affect patients' choice of treatment (for example, the type of operation performed), which is typically based on their clinicians' advice. PMIs are therefore unlikely to affect most insured patients' demand in a way that leads insured patients to substitute across different treatments.
- 5.12 Patients may consider having their treatment funded by the NHS instead of funding it privately themselves or through their PMI. Hence, we have considered whether patients of privately-funded healthcare would switch to NHS-funded healthcare in the case of a small change in prices or quality of the services provided.
- 5.13 We have looked at the results of our survey of patients. While this survey indicates that one-fifth of insured patients considered having their treatment on the NHS,<sup>182</sup> only 3 per cent would have switched to the NHS if their chosen private hospital was unavailable.<sup>183</sup> Furthermore, 90 per cent of insured patients stated that a reason for choosing privately-funded healthcare was to make use of their PMI.<sup>184</sup> As expected, the readiness of self-pay patients to consider the NHS was significantly higher, with 68 per cent of self-pay patients considering having their treatment on the NHS;<sup>185</sup> however, only 12 per cent would have switched to the NHS if their chosen private hospital was unavailable.<sup>186, 187</sup>
- 5.14 Among the reasons for choosing privately-funded healthcare, patients have most commonly cited that they wanted to take advantage of the reduced waiting times (76 per cent of insured patients and 75 per cent of self-pay patients), the better comfort and quality of accommodation (54 per cent of insured patients and 37 per cent of self-pay patients), the greater availability of appointment times (55 per cent of insured patients and 35 per cent of self-pay patients), and the ability to choose a specific private consultant (39 per cent of insured patients and 42 per cent of self-pay patients).<sup>188</sup>
- 5.15 We have also considered previous CC and OFT decisions as well as EU merger investigations.<sup>189</sup> The view taken in these cases is that, although the NHS provides an element of price constraint, the willingness of consumers to pay an extra charge for private acute healthcare is an indication of this being a different market from the NHS. The NHS as a whole has therefore been considered to be in a separate market

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<sup>182</sup> Table B2 of [CC patient survey](#).

<sup>183</sup> Table D6 of [CC patient survey](#).

<sup>184</sup> Table B1 of [CC patient survey](#).

<sup>185</sup> Table B2 of [CC patient survey](#).

<sup>186</sup> Table D6 of [CC patient survey](#).

<sup>187</sup> HCA said that our patient survey did not address market definition: it did not consider patient reactions to a small increase in price or a decrease in quality (it made a similar point on our consultants and GPs surveys); it obtained information on the average patient and not the marginal patients; and it failed to query whether policyholders' preferences changed for highly complex procedures that may require intensive care support ([HCA response to Provisional Findings](#), paragraphs 5.8, 5.14 and 5.26). We did not include these types of question in our surveys for a number of reasons. First, we assessed competitive effects both inside and outside our market definitions. Secondly, we used other sources of information, eg internal documents of the parties. Thirdly, questions on small price changes would not apply to insured patients at the point of treatment. HCA said that we failed to determine PMI customers' willingness to consider the NHS at the point of purchasing their policies. It can be difficult reliably to relate questions about reactions to small price changes to policies to the behaviour of the hospital operators, eg a 5 per cent increase in the price of policies will equate to a much larger price increase for hospital operators. Fourthly, it can be difficult to reliably frame questions on small changes in quality.

<sup>188</sup> Table B1 of [CC patient survey](#).

<sup>189</sup> See OFT Private Healthcare Market Study, April 2012, paragraphs 4.36–4.41, for references to relevant OFT, CC and European Commission Decisions. [www.of.gov.uk/shared\\_of/market-studies/OFT1412.pdf](http://www.of.gov.uk/shared_of/market-studies/OFT1412.pdf).



from private acute healthcare.<sup>190</sup> We considered that the results of our survey of patients are consistent with this conclusion.

- 5.16 Based on the above considerations, demand-side substitution by patients across different treatments, if any, appears to be very limited. As such, the starting point for product market definition is one of narrowly delineated product markets covering each different medical treatment. In addition, privately-funded medical treatments appear to be in a separate product market from NHS-funded medical treatments as a whole.<sup>191</sup> We note that constraints from NHS hospitals on private hospitals have been taken into account in the competitive assessment, on a case-by-case basis, where we have evidence that these exert a competitive constraint. In what follows, for simplicity, we will use the term medical treatments to refer to privately-funded medical treatments, unless otherwise specified.

### *Supply-side substitution by consultants*

- 5.17 There is supply-side substitution if a private healthcare provider (ie a consultant or a hospital) has the ability and incentive to switch production capacity easily and rapidly into the provision of a treatment in the event of an increase in the relative market price of that treatment. Switching can refer to starting the provision of a treatment that was not previously offered, or merely to increasing the provision of a treatment that was already offered, by dedicating additional capacity to its provision.
- 5.18 Consultants are typically qualified to work in a single specialty.<sup>192</sup> Obtaining the qualifications and skills needed to start working in additional specialties requires a substantial investment, both in terms of time and of financial resources. Consultants are often specialized in the provision of certain treatments within the specialty they are qualified in. However, there appears to be some ability for consultants to provide a wider range of treatments within these specialties, especially in the case of more routine treatments.
- 5.19 Overall, we considered that in the provision of consultant services, there is typically no supply-side substitution across treatments in different specialties, but there is some degree of supply-side substitution across treatments within the same specialty. We therefore concluded that each specialty should be viewed as a separate product market in the provision of consultant services.

### *Supply-side substitution by hospitals*

- 5.20 Hospitals combine a series of production assets and inputs to provide a range of treatments in a number of different specialties. These assets and inputs include, for instance, hospital facilities, medical equipment, healthcare professionals and consultants. With the exception of consultants and some specialized medical equipment, most of the hospitals' production assets and inputs can be used for the provision of a wide range of treatments. This is, for instance, the case for overnight rooms, consulting rooms, theatres, or most medical equipment. Healthcare professionals employed by the hospital (for example nursing staff) are often qualified to collaborate in the provision of a variety of treatments in different specialties. Hospitals have the ability

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<sup>190</sup> See, in particular, CC [Bupa/CHG merger report](#), December 2000, paragraph 4.54.

<sup>191</sup> As set out in paragraph 5.4, we have considered PPUs in NHS hospitals as providers of private healthcare in the UK.

<sup>192</sup> Consultants who practice within the UK health service must be on the GMC specialist register. Before being entered on the specialist register the GMC will check that the consultant is appropriately qualified in their specialty. Source: [www.gmc-uk.org/doctors/before\\_you\\_apply/background.asp](http://www.gmc-uk.org/doctors/before_you_apply/background.asp). See paragraph 3.67.

to switch these production assets and inputs into the provision of different treatments if required.

- 5.21 As set out below, the evidence submitted to us shows that hospitals continuously introduce new treatments into their product range. On one hand, this is a consequence of new health technologies being gradually adopted, either replacing older technologies or enlarging the range of technologies available. On the other hand, hospitals incorporate new treatments as a response to changing market conditions (eg new demand, changing competitive environment). For the purpose of market definition and the identification of the relevant competitive constraints, we are primarily interested in the latter, as they are likely examples of the hospitals' ability to switch the use of production assets easily and rapidly.

*Within and between specialties*

- 5.22 We looked at the evidence provided on the hospitals' ability rapidly and easily to switch capacity into the provision of new medical treatments within specialties already provided at the hospitals ('existing' specialties) or into the provision of treatments in specialties not previously provided ('new' specialties).
- 5.23 BMI submitted that 'switching between treatments within a specialty ... and between specialties ... occurs in the usual competition sense, ie in response to relatively modest changes in returns available from the assets of the hospital'. Spire submitted evidence that it 'has used both existing capacity and investment in its hospitals to develop new services, expand into new therapeutic areas, and increase the quality/ range of services offered to patients'. HCA told us that in the provisional findings we were incorrect to have concluded that there is limited supply-side substitution between providers of different specialties. HCA also disagreed with the CC's different treatment of Oncology compared with other specialties.<sup>193</sup>
- 5.24 The evidence presented below shows that there is significant variation in the cost incurred when switching capacity into the provision of new treatments and in the time requirements to execute the switch. In a number of cases, switching capacity has involved no cost or little cost and hospitals have been able to start providing the new treatments either immediately or after a few months. In some other cases, switching capacity has involved larger investments (up to a few million pounds) and longer time frames (up to a year).
- 5.25 Most examples provided in response to the market questionnaire involved cases of hospitals switching capacity into the provision of new treatments within specialties already offered by the hospital, for example:

(a) Chemotherapy for lung cancer at BMI Blackheath:

No capital was required for this treatment (as it falls within an existing specialty—oncology) and there were no significant switching costs. The hospital utilised existing spare capacity in its Oncology Suite and attracted new consultants from HCA London Bridge and Guy's and St Thomas's NHS Hospitals.

(b) Urodynamics at Spire Portsmouth:

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<sup>193</sup> [HCA response to Provisional Findings](#), paragraph 5.112.

The expansion of current urodynamics service was considered necessary to support a full service in conjunction with the Well Women physiotherapy service. The necessary equipment was rented from an external company on six monthly rental agreement totalling [£]. A bank of urodynamics nurses were recruited to perform urodynaics tests. It took [£] to launch the service, which included: sourcing the equipment; negotiating the service contract; and recruiting the specialised nurses. The total cost of the project was [£].

(c) Hip arthroscopies at Ramsay Duchy:

In order to be able to provide this new service Duchy purchased a hip scope set at a cost of [£]. All of the other equipment required, including a table attachment and camera system were already available. Accordingly, this service was immediately commenced upon purchase of the relevant equipment.

(d) Static CT at Spire Gatwick Park:

The development of the static CT necessitated the hire of radiographers to operate the new scanner at 1.5 whole time equivalents. There were no implications for consultant recruitment ... Building costs were [£] with a further [£] for the purchase of the scanner. The capital project cost was [£] and took approximately [£] to complete.

- 5.26 In relation to switching capacity into new treatments within a specialty already offered by the hospital, BMI submitted that this 'is fast, common and subject to low switching costs. Often, a hospital can switch to a new medical treatment without requiring capital expenditure and using existing equipment and consultants.'
- 5.27 There have been relatively fewer cases of hospitals that started the provision of treatments in new specialties since 2006. The cases below were typically more costly and took more time than in the cases where the hospital already offers some treatments in the relevant specialty, for example:

(a) Neurosurgery at BMI Shirley Oaks:

The hospital has also started a neurosurgery service that was not previously offered. A new consultant was recruited. There was no impact on staffing although capital costs were in the region of [£].

(b) ICU plus head & neck surgery at HCA Lister:

The development of intensive care services has facilitated the development of new service lines such as head and neck surgery which could not have been undertaken at the hospital in the absence of an intensive care unit. ... The service was created by redeveloping 6 out-patient consulting rooms at the hospital. ... New consultants were recruited from the Royal Marsden, Hammersmith and Chelsea and Westminster NHS Hospitals. ... There was a need to recruit new staff to operate the intensive care services including experienced intensive care nurses. The development has cost approximately [£] million.

(c) Liver surgery and transplantation at HCA London Bridge:

HCA developed a new liver surgery and transplantation unit at the London Bridge Hospital. HCA attracted a liver transplantation team comprising nurses, intensivists and interventional radiologists which enabled the service to be developed.

(d) BMI Blackheath Intensive Care Unit:

BMI Blackheath is installing an ITU facility at the moment at a budgeted capital cost of [£] with the time to complete the facility being six to nine months.

(e) Spire provided a number of examples of switching to provide treatments in new specialties including the introduction of cardiac surgery at Spire Cambridge Lea and Spire Cardiff and the introduction of neurosurgery and cardiology at Tunbridge Wells.

- 5.28 In relation to switching into new specialties, Spire submitted that 'since 2007 ... many hospitals have started to offer medical treatments in a specialty the hospital did not previously provide'. The ease with which hospitals can switch capacity into the provision of new treatments, especially in a new specialty, seems critically to depend on the availability of qualified consultants. According to BMI, 'the ease or difficulty of switching between specialities depends on two linked factors: ... the nature of the change required, and ... the availability of suitably qualified consultants'. Ramsay also submitted that '[£] in determining whether a hospital can deliver a new service/new type of treatment is the consultant'.
- 5.29 The extent to which hospitals have spare capacity has an impact on their ability and incentives to introduce new treatments both within existing specialties and in new specialties. Evidence suggests that most hospitals in the UK have substantial spare capacity. The five largest hospital groups (which combined account for approximately 70 per cent of revenues) have reported substantial spare capacity in their hospitals (below [£] per cent utilization of operating theatres and overnight beds on average). For instance, in response to our Market Questionnaire, Ramsay submitted that [£]. A BMI presentation to PMIs also described a problem of overcapacity in the industry, and stated that on average only 40 per cent of hospitals were profitably utilized. In the presentation, BMI also outlined its proposals to reduce overcapacity through offering directional power for PMIs to opt to concentrate their demand at the best hospitals, rationalizing the supply side, increasing utilization, bringing down average episode cost, bringing down prices to PMIs and ultimately lower private insurance premia.
- 5.30 Substantial spare capacity is likely to imply relatively low opportunity costs of introducing new treatments if the result is a higher level of capacity utilization. This contributes to enhance the incentives to supply-side substitution.
- 5.31 We have received evidence of switching into the provision of new treatments both within existing specialties and in new specialties. The evidence indicates that this switching has been more common for treatments within specialties already provided by the hospitals than for treatments in new specialties.<sup>194</sup> In relation to the latter, the availability of qualified consultants appears to be the main factor constraining the ease with which hospitals can switch into the provision of treatments in new

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<sup>194</sup> We note, however, that the fewer examples of switching capacity into new specialties may be explained by the fact that most hospitals already provide most of the main specialties typically available in private healthcare (see Table 5.2).

specialties. We also note that the examples we have reviewed indicate that introducing treatments in new specialties can involve a higher capital expenditure and it can take more time.

*Between inpatient, day-patient and outpatient care*

- 5.32 Outpatient treatments are generally defined as those treatments which do not require a patient to be admitted to hospital, whereas inpatient treatments require patients' admission to hospital (and also involve an overnight stay). There is also an 'in-between' case where a patient is admitted but the treatment is completed within the day (ie patients do not stay overnight): these are referred to as 'day cases' or day-patient treatments. Most of the specialties have both an inpatient and an outpatient element (though there are some specialties that include only, or to a very large extent, outpatient treatments, eg rheumatology).
- 5.33 Outpatient care includes first and follow-up consultant appointments but also diagnostic treatments that do not require admission. In some cases, outpatient treatments will form part of an admitted care pathway, for example being assessed in an outpatient appointment before (or after) being admitted to have a surgical treatment. In some cases, patients can receive outpatient treatments from the same hospital which provides the inpatient treatment. In other cases, outpatient treatments will be offered on a stand-alone basis.
- 5.34 We looked at the evidence on the ability of hospitals (distinguishing between hospitals that provide inpatient care and day-only/outpatient clinics that provide only day-case and/or outpatient care) to rapidly and easily switch capacity into the provision of new medical treatments across inpatient, day-patient and outpatient care for a given specialty.
- 5.35 Data from the five largest hospital operators shows that day-patient admissions accounted for 58 per cent of total admissions (inpatient plus day-patient) in their hospitals in 2006, and for 68 per cent in 2011. Revenue data shows a similar trend: revenue from day-patient admissions in hospitals of the five largest hospital operators accounted for 29 per cent of total revenue from admitted patients (inpatient plus day-patient) in 2006, and for 37 per cent in 2011. These figures indicate that there has been a trend from inpatient towards day-patient treatments and that hospitals with inpatient capacity have been able to switch capacity effectively towards day-patient care.
- 5.36 Parties pointed out the increasing importance of outpatient and day-patient care both in terms of number of outpatient visits and day-patient admissions, and in terms of revenue. For instance, BMI submitted that 'modern private hospitals are places where the great majority of people treated are on an outpatient, day case and walk-in walk-out basis. Looking at inpatient work alone does not reflect the true nature of competition between hospitals.' Spire submitted that 'it is wrong to think that day-case and outpatient treatments are peripheral to private healthcare priorities in the UK: in fact, they represent the core of the business and there is trend toward moving more procedures to a day-case or outpatient environment'. HCA told us that there was a lack of a clear demarcation between in-, day- and outpatient services which had an impact on the possibility for supply-side substitution and more generally the competitive constraint between them.<sup>195</sup>

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<sup>195</sup> HCA response to Provisional Findings, paragraph 5.113.

- 5.37 Parties also commented on the competitive constraints between inpatient, day-patient and outpatient care. For example, Bupa submitted that ‘care in an outpatient and/or day-case setting offers little constraint on care that must be delivered in an inpatient setting’. However, Spire submitted that ‘one recent model for entry into private healthcare services is to start with a smaller facility providing outpatient and/or day-case services and then expand into inpatient services’.<sup>196</sup>
- 5.38 While we acknowledge the trend from inpatient towards day-patient and outpatient care, we note that there are asymmetries between hospitals that provide inpatient care and day-only/outpatient clinics in their ability rapidly and easily to switch capacity into the provision of new medical treatments across inpatient, day-patient and outpatient care for a given specialty. In particular, hospitals that provide inpatient care also typically provide day-patient and outpatient care in the same specialty. As a result, hospitals with overnight capacity could quickly and easily switch capacity across inpatient, day-patient and outpatient care. The figures presented above that hospitals with inpatient capacity have effectively switched from inpatient care to day-patient and outpatient care over the last years (see paragraph 5.35) support this conclusion.
- 5.39 Day-only/outpatient clinics, on the contrary, because of the scale of the investment and the time required, appear to have a very limited ability rapidly and easily to switch capacity into the provision of inpatient care. Any such switching appears more relevant to the assessment of entry rather than of supply-side substitution. In fact, we found only one record of a day-only clinic having entered into the provision of inpatient care at least since 2006.

#### *Conclusion on supply-side substitution by hospitals*

- 5.40 Overall, there appears to be a significant degree of supply-side substitution across treatments within the same existing specialty. Within each given specialty, however, supply-side substitution appears to be greater for more routine treatments, which do not require highly-specialized equipment and staff, than for more complex treatments. There is more limited evidence of hospitals switching to treatments in new specialties. Moreover, within each given specialty, while there appears to be scope for hospitals that provide inpatient care to switch capacity into the provision of day-patient and outpatient treatments, the ability to switch by day-only/outpatient clinics into the provision of inpatient treatments appears very limited (ie asymmetric constraints appear to exist).

#### *Same set of hospitals*

- 5.41 We looked at whether the same hospitals compete to provide different medical treatments under similar conditions of competition.
- 5.42 We have looked at a set of 255 private hospitals including PPU's across the UK, including:
- (a) all 169 private hospitals operated by BMI, HCA, Nuffield, Ramsay and Spire;
  - (b) another 23 of the largest private hospitals operated by private hospital operators including Aspen, Circle, and HMT;

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<sup>196</sup> [Spire response to annotated issues statement](#), paragraph 3.7.a. Spire provided one example of such an entry event: Nuffield Vale in Cardiff ‘started by providing outpatient consulting services on the premises of a leisure club and has expanded to become a full-service hospital with two operating theatres and twenty-five bedrooms’.

(c) all 16 PPUs managed by BMI, HCA, Ramsay and East Kent Medical Services; and

(d) 47 PPUs operated by the 30 largest NHS trusts across the UK.

5.43 According to Laing & Buisson,<sup>197</sup> the total revenue of private independent acute medical hospitals and clinics was £4,352 million in the UK in 2012. The revenue of the operators owning or managing the 192 private hospitals we have looked at account for more than 80 per cent of this total revenue. Also according to Laing & Buisson, the total revenue generated by NHS private patients treated by private operators was £1,195 million in the UK in 2012. The 30 largest NHS trusts by private patient revenue account for 50 per cent of total NHS private patient revenue. Overall, the set of 264 private hospitals and PPUs we have looked at accounted for more the 75 per cent of all private patient revenue in the UK in 2012.

5.44 As part of our assessment of local competitive constraints, the conditions of competition in each local market were assessed on a case-by-case basis for those hospitals we identified as being of potential concern (see Section 6).

#### *General versus specialized providers*

5.45 In terms of the range of specialties provided, the vast majority of the private hospitals and PPUs we analysed are not specialized in a single specialty (or treatment)—hereafter, we refer to them as ‘general’ private hospitals and PPUs. As shown in Table 5.1, out of 255 private hospitals and PPUs we analysed, 185 are general private hospitals and 51 are general PPUs providing a varying range of specialties and treatments.

TABLE 5.1 Number of general and specialized hospitals/PPUs by operator in our set

Operator	General private hospitals	Specialized private hospitals	General PPUs	Specialized PPUs
BMI	59	0	10	0
HCA	12	5	1	2
Nuffield	32	0	0	0
Ramsay	24	0	0	1
Spire	37	0	0	0
Independent	21	2	2	0
NHS Trusts	0	0	38	9
Total	185	7	51	12

Source: CC analysis.

\*These figures do not include a general private (day-only) hospital owned by Aspen and a general private hospital owned by Spire, either acquired or open after the submission of responses to the Market Questionnaire.

#### *Inpatient, day-patient and outpatient care*

5.46 Focusing on general private hospitals and general PPUs, 164 out of 185 general private hospitals and all general PPUs provide inpatient care as well as day-patient and outpatient care. This adds up to 215 general private hospitals and general PPUs offering inpatient, day-patient and outpatient care, on which we have largely focused our competitive assessment.

5.47 The general private hospitals and general PPUs we have looked at do not include a substantial number of day-only clinics active across the UK. According to Laing &

<sup>197</sup> Laing and Buisson, *Private Acute Medical Care*, UK Market Report 2013, p13.

Buisson, there were 264 day-only clinics in the UK in 2013.<sup>198</sup> Most of them are relatively small clinics: according to Laing & Buisson they account for 27 per cent of all private day-case admissions in the UK in 2012, while the remaining 73 per cent of admissions took place in private hospitals that also provided inpatient care.<sup>199</sup>

- 5.48 General private hospitals and general PPUs providing inpatient care compete with each other in the provision of inpatient care and are the only providers of inpatient care. In general, they compete with a wider set of providers, including day-only/outpatient clinics, in the provision of some day-patient and/or outpatient care. In relation to the latter, however, we note that day-only/outpatient clinics may not be competing with general private hospitals and general PPUs across the full range of day-patient and outpatient treatments. For example, because of their complexity, some day-patient treatments may take place predominantly in hospitals able to provide inpatient care as back-up if needed. Also, outpatient visits are often ancillary to inpatient and day-case treatments, either as part of the diagnostic stage or as follow-ups, and may frequently take place in the same hospital where the main inpatient or day-patient treatment has taken or will take place.

*Specialties most commonly provided*

- 5.49 While most general private hospitals and general PPUs provide a range of specialties, not every specialty is offered at every single hospital. In order to assess the extent to which the same hospitals are active in the provision of treatments across different specialties, we have identified the specialties most commonly offered by the 215 general private hospitals and general PPUs offering inpatient care in our set.
- 5.50 Table 5.2 shows that 16 specialties<sup>200</sup> are offered by 80 per cent or more of these 215 general private hospitals and general PPUs. These 16 specialties accounted for 86 per cent of total admissions and for 75 per cent of total revenue at these hospitals in 2011.

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<sup>198</sup> *ibid.*

<sup>199</sup> *ibid.*, Table 6.1, p119.

<sup>200</sup> These specialties are obstetrics and gynaecology, general surgery, trauma and orthopaedics, anaesthetics, urology, gastroenterology, ophthalmology, otolaryngology, dermatology, plastic surgery, cardiology, general medicine, neurology, oral and maxillofacial surgery, rheumatology and clinical radiology.



TABLE 5.2 Set of specialties offered by at least 80 per cent of the 215 private hospitals/PPUs in 2011

Specialty	per cent		
	Share of hospitals offering the specialty	Share of total admissions (inpatient and day case)	Share of total revenue (inpatient, day case and outpatient)
Obstetrics and gynaecology	95.4	7.6	6.9
General surgery	93.5	13.5	9.5
Trauma and orthopaedics	93.0	27.0	30.5
Anaesthetics	93.0	2.3	0.9
Urology	91.6	6.7	4.1
Gastroenterology	88.9	6.1	3.0
Ophthalmology	88.8	5.8	2.3
Otolaryngology	88.4	3.6	2.2
Dermatology	86.5	0.3	0.6
Plastic surgery	86.5	4.0	3.1
Cardiology	85.6	1.3	4.5
General medicine	83.3	3.2	3.3
Neurology	82.8	0.3	1.1
Oral and maxillofacial surgery	80.9	3.2	0.8
Rheumatology	80.9	0.1	0.3
Clinical radiology	80.0	1.1	1.5
Total	N/A	86.1	74.6

Source: CC analysis.

Note: N/A = not applicable.

5.51 Oncology stands out as the main specialty accounting for a relatively large share of total admissions and total revenue that is not among the specialties offered by more than 80 per cent of the 215 general private hospitals and general PPUs with inpatient care.<sup>201</sup> In particular, oncology accounted for 9.6 per cent of total admissions and 7.5 per cent of total revenue at these hospitals in 2011. However, oncology care was only provided by 68.8 per cent of these hospitals. Moreover, a number of private hospitals and PPUs are specialized in the provision of oncology care. The set of hospitals providing oncology appears therefore to be different from the set of hospitals active across the 16 specialties identified above. Out of 215 general private hospitals and general PPUs providing inpatient care, 135 have been reported to offer oncology treatments. In addition to these, four specialized private hospitals and PPUs providing inpatient care have been reported to specialize in oncology.

### Conclusions on product market(s)

5.52 On the basis of the evidence and analysis set out in the previous sections, we found that:

- (a) Due to the fact that demand-side substitution by patients across different medical treatments is likely to be very limited, the starting point for product market definition is one of narrowly delineated product markets covering each different medical treatment. In addition, privately-funded medical treatments appear to be in a separate product market from NHS-funded medical treatments as a whole.
- (b) In the provision of consultant services, there is typically limited supply-side substitution across treatments in different specialties, but there is some degree of supply-side substitution across treatments within the same specialty.
- (c) In the provision of hospital services:

<sup>201</sup> Hence, the 16 specialties plus oncology accounted for more than 95 per cent of total admissions and more than 82 per cent of total revenue in 2011. All other specialties together accounted for 5 per cent of total admissions and part of the remaining 18 per cent of total revenue, while the remainder was revenue from non-patient-related activity.

- (i) There is a significant degree of supply-side substitution across treatments within the same existing specialty. Within each given specialty, however, supply-side substitution is greater for more routine treatments, which do not require highly-specialized equipment and staff, than for more complex treatments. There is more limited evidence of hospitals switching to treatments in new specialties. Within each given specialty, while there appears to be scope for hospitals providing inpatient care to switch capacity into the provision of day-patient and outpatient treatments, the ability to switch into the provision of inpatient treatments by day-only/outpatient clinics, which provide only outpatient and/or day-patient care, appears very limited (ie asymmetric constraints appear to exist).
- (ii) Focusing on the 215 general private hospitals and general PPUs which provide inpatient care,<sup>202</sup> 16 specialties are offered by 80 per cent or more of these hospitals. These 16 specialties accounted for 86 per cent of total admissions<sup>203</sup> and for 75 per cent of total revenue<sup>204</sup> at these hospitals in 2011.
- (iii) Oncology is the main specialty accounting for a relatively large share of total admissions and total revenue that is not among the specialties offered by more than 80 per cent of the 215 general private hospitals and general PPUs with inpatient care. In particular, oncology accounted for 9.6 per cent of total admissions and 7.5 per cent of total revenue at these hospitals in 2011. Oncology is currently offered by 135 (64.7 per cent) of the 215 general private hospitals and general PPUs which provide inpatient care, plus four specialized private hospitals and PPUs providing inpatient care.

5.53 On the basis of these findings, the approach we took in relation to product market definition is the following:

- (a) In the provision of consultant services, each specialty is considered as a separate product market.
- (b) In the provision of hospital services:
  - (i) Given the significant degree of supply-side substitution across treatments within an existing speciality, the market is not limited to the treatment, but extends to the speciality. Given the more limited supply-side substitution across treatments in new specialties, the market is no wider than each speciality.
  - (ii) Given the existence of asymmetric constraints between hospitals providing inpatient care and day-only/outpatient clinics, for each specialty, inpatient, day-patient and outpatient care are considered to be distinct product markets.

5.54 On the basis of the above findings, we took the following approach in relation to the assessment of competitive constraints in the provision of hospital services:

- (a) Although we have defined separate markets for inpatient, day-patient and outpatient care, the boundaries of these markets are blurred to some extent. As

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<sup>202</sup> Including: (a) all private general hospitals with inpatient care owned by BMI, HCA, Nuffield, Ramsay and Spire; (b) 19 of the largest other private general hospitals with inpatient care (including Aspen and Circle); (c) all general PPUs with inpatient care managed by BMI, HCA, Ramsay and East Kent Medical Services; and (d) the 40 largest general PPUs with inpatient care by revenue.

<sup>203</sup> Including inpatient and day-patient.

<sup>204</sup> Including inpatient, day-patient and outpatient care.

noted in paragraph 5.48, some day-patient and outpatient treatments (eg those which require inpatient care as a back-up or those which are ancillary to an inpatient treatment) are likely to be provided by the hospitals that provide inpatient care. Hence, while we acknowledge that in general hospitals providing inpatient care compete with a wider set of providers, including day-only/outpatient clinics, in the provision of some day-patient and/or outpatient care, this is unlikely to hold across the full range of day-patient and outpatient treatments. In particular, some day-patient and outpatient treatments are likely to be subject to similar competitive conditions as those arising in the provision of inpatient treatments. For the reasons set out in paragraph 6.4, our competitive assessment has focussed largely on hospitals providing inpatient care.<sup>205</sup> The set of hospitals we have looked at therefore includes the 215 general private hospitals and general PPUs and four specialized private hospitals and PPUs providing inpatient care.

- (b) We concluded that each specialty is considered as a separate product market. However, supply-side substitution appears to be greater across treatments in different specialties when the hospital already provides the relevant specialties. Given that many hospitals in our set are already active in the provision of treatments across a set of 16 specialties, and are therefore well placed to expand into new treatments across each of those specialties, for the purposes of the assessment of competitive constraints we have aggregated the 16 specialties together where we considered it appropriate. Given that fewer hospitals in our set are active in the provision of oncology compared with the other 16 specialties, we have looked at oncology separately in our competitive assessment where possible.
- (c) Given that, within each specialty, supply-side substitution appears to be greater for more routine treatments than for more complex treatments, in our competitive assessment we considered constraints within these markets arising in the provision of more complex treatments (also referred to as 'high acuity' or 'tertiary' care).<sup>206</sup>
- (d) In our competitive assessment we considered constraints from outside the markets exerted by NHS hospitals, ie providers of NHS-funded treatments, on a case by case basis, where we have evidence that these exert a competitive constraint.

## **Geographic markets**

- 5.55 As set out in the CC Guidelines,<sup>207</sup> geographic markets may be based on the location of suppliers and defined as an area covering a set of firms or outlets which compete closely because enough customers consider them to be substitutes (as in the case of retail markets and some industrial markets).
- 5.56 In the provision of (private) healthcare, most patients have a preference to travel shorter distances, everything else equal, and to choose local consultants and hospitals to receive medical treatment.<sup>208</sup> The results of our survey of patients indicate

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<sup>205</sup> In the remainder of this section we will refer to 'hospitals' or 'private hospitals' as private healthcare facilities including PPUs providing inpatient care, unless otherwise specified. Hospital services will include all medical treatments carried out by a hospital on an inpatient, day-case and/or outpatient basis.

<sup>206</sup> See Appendix 6.7. We looked, for example, at 'tertiary' treatments—those requiring a referral from a consultant to another consultant.

<sup>207</sup> CC3, paragraph 145.

<sup>208</sup> As indicated by most parties to this inquiry, as well as the CC patient survey and patient invoice data.

that both the actual journey time and the willingness to travel of patients were very similar for consultant and hospital services.<sup>209</sup> These indicate that the geographic scope of competition in the provision of private healthcare services is local for both consultant and hospital services, and is likely to be broadly similar in the two cases.<sup>210</sup>

- 5.57 In relation to consultant services, we conclude that the geographic market is local. However, for the purposes of our analysis, it is not necessary to define these markets, as this will not have any impact on our findings.
- 5.58 In relation to hospital services, local geographic markets may thus be defined as the areas covering sets of private hospitals and PPUs competing closely because enough patients consider them to be substitutes. Having regard to patients' preferences, the relevant dimension of closeness of competition for this purpose is the distance between providers and their location. Following the CC Guidelines, in the case of supplier-based markets, in identifying the set of competing hospitals for the purpose of geographic market definition, the CC may consider information on catchment areas from which the bulk of a hospital's patients are drawn and which hospitals customers (ie patients and PMIs) consider to be substitutes for each other.<sup>211</sup>
- 5.59 For hospitals located in the central London area we considered the evidence on which hospitals customers consider to be substitutes for each other (the evidence is set out in more detail in Appendix 6.10). First, we observe that market conditions in central London, both on the demand side and on the supply side, differ markedly from those prevailing elsewhere in the UK or are more evident in central London than elsewhere (see paragraphs 3 to 34 of Appendix 6.10). In particular, central London is characterized by a high PMI penetration rate, in part arising from the large presence of corporate PMI customers; a significant number of patients travelling from greater London and outer London into central London; a significant number of private hospitals and PPUs, with a widespread offer of complex treatments or specialties; strong reputation of some private hospitals and PPUs which are perceived by patients as offering a higher quality of care than private hospitals and PPUs elsewhere in the UK; and private hospitals and PPUs in general drawing patients from very wide geographic areas. Second, we note that PMIs, but also some hospitals operators, consistently expressed the view that hospitals located in central London (and possibly a subset of these) are closer substitutes for each other (see, in particular, Appendix 6.10, Annex A, paragraphs 6 to 9, 16, 18, 23 to 26, and 42 to 46). This evidence indicates that the area covering the set of private hospitals and PPUs located in central London should be regarded as a distinct geographic market. The private hospitals and PPUs located in central London are identified in our competitive assessment for central London.<sup>212</sup>
- 5.60 We note, however, that as location and distance are important to patients (and to GPs referring patients to secondary care) when they choose a hospital, even within central London, hospitals providing the same services in different locations are not perfect substitutes for one another and, other things being equal, hospitals that are

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<sup>209</sup> CC patient survey, questions E1A, E1B, E2A, E2B, Survey of Patient Report, slides 48 & 49.

<sup>210</sup> It is possible that in some cases the geographic markets for consultant services could be slightly wider than those for hospital services due to consultants using several hospitals and patients being normally referred by GPs for secondary care to see a consultant rather than a hospital.

<sup>211</sup> CC3, paragraph 148.

<sup>212</sup> For the purpose of identifying central London hospitals we used a delineation of central London as the area inside the North and South Circular Roads. We note that, in terms of where hospitals are located, this delineation is consistent with the NUTS2 region of Inner London (NUTS stands for 'Nomenclature of Territorial Units for Statistics' and is a delineation of geographic areas developed and regulated by the EU).

near one another may be expected to exert a stronger competitive constraint than hospitals located further away.

- 5.61 Taking the above consideration into account, regardless of the precise boundaries of the geographic market, in our competitive assessment for central London we have taken into account the relative strength of the competitive constraints exerted by different private hospitals/PPUs within central London on each other. We have also taken into account the competitive constraints exerted on private hospitals/PPUs located in central London by private hospitals/PPUs located outside central London and we have considered constraints by NHS hospitals where we have evidence that these exert a competitive constraint.
- 5.62 For hospitals located outside central London, recognizing that there are a significant number of private hospitals and PPUs throughout the UK, we based the geographic market definition on catchment areas from which the majority of a hospital's patients are drawn.
- 5.63 Catchment area analysis is a pragmatic approach that has been used by the OFT and the CC in several previous inquiries involving a large number of local markets.<sup>213</sup> However, this approach has a number of limitations.<sup>214</sup> We note, in particular, the following points.
- 5.64 The catchment area around a hospital reflects the area from which the hospital draws the majority of its patients and does not necessarily fully reflect patients' willingness to travel in response to a small change in the price or quality of the services provided by the hospital they have attended. This may result in geographic markets defined on the basis of catchment areas possibly being too narrow in some instances. However, as explained below, we have considered in our local competitive assessment the constraints on each hospital, whether arising within or outside the hospital's catchment area.
- 5.65 In addition, as location and distance are important to patients (and to GPs referring patients to secondary care) when they choose a hospital, even within the local geographic markets thus defined, hospitals providing the same services in different locations are not perfect substitutes for one another and, other things being equal, hospitals that are near one another may be expected to exert a stronger competitive constraint than hospitals located further away. We have taken into account these different levels of constraints in our competitive assessment.
- 5.66 Moreover, hospitals are different and some have different size catchment areas, which in turn may depend on a number of factors such as the size of the hospital, the range of specialties/treatments provided (including whether the hospital provides high-acuity/complex treatments) and the area where the hospital is located (major conurbations, urban or rural areas). For example, having a large catchment area does not necessarily imply that the hospital is constrained by all hospitals located within its catchment area. Similarly, a small catchment area does not necessarily imply that the hospital is not constrained by hospitals located outside its catchment area.

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<sup>213</sup> See [CC3](#), paragraph 148(a); [CC2](#), paragraph 5.2.25; *Commentary on retail mergers*, a joint report by the OFT and the CC, March 2011. In relation to (private) healthcare, see references in the OFT [Private Healthcare Market Study](#), April 2012, paragraphs 4.46–4.48.

<sup>214</sup> See Oxera, [Report prepared for the OFT, Techniques for defining markets for private healthcare in the UK](#), November 2011.

- 5.67 Finally, we note that hospitals' catchment areas can overlap, to a greater or lesser extent, with each other, and this may provide an indication of the extent to which different hospitals are considered by patients to be substitutes for each other.
- 5.68 Taking these considerations into account, for the rest of the UK (ie excluding central London) we have used each hospital's catchment area as a pragmatic definition of the geographic market. However, regardless of the precise boundaries of these geographic markets, in our local competitive assessments for each hospital we have taken into account the relative strength of the competitive constraints exerted by different private hospitals/PPUs within the hospital's catchment area and we have considered constraints provided by private hospitals/PPUs located outside the hospital's catchment area. In particular, we have looked at any overlap with other private hospitals' catchment areas, including hospitals inside and outside the hospital's catchment area, to identify, for each hospital, the set of private hospitals/PPUs which the assessment of competitive constraints should focus on. We have also considered constraints provided by NHS hospitals where we have evidence of them being a constraint.
- 5.69 In Appendix 6.4 we set out the details of our methodology to identify catchment areas. For each hospital, the catchment area size (in terms of road distance) and the set of private hospitals/PPUs which the assessment of competitive constraints has focused on are presented in the individual hospital competitive assessment in Appendix 6.7. The same applies to NHS hospitals where we have evidence of them acting as a constraint.

### *Conclusion on geographic market(s)*

- 5.70 On the basis of the evidence and analysis set out above, we decided upon the following approach to geographic market definition for the provision of private healthcare and the assessment of competitive constraints:
- (a) We treat the geographic scope of competition in the provision of private health-care services as local for both consultant and hospital services.
  - (b) In relation to consultant services, for the purposes of our analysis we did not consider it necessary to identify these local geographic markets, it being sufficient to understand them as similar in scope to hospital services markets.
  - (c) In relation to hospital services, we have defined the local geographic markets on the basis of the location of suppliers. Local geographic markets are defined as the areas covering sets of private hospitals and PPU's competing closely because enough patients consider them to be substitutes in terms of distance. In particular:
    - (i) we have considered the area covering the private hospitals and PPU's in central London as a separate geographic market;
    - (ii) in the rest of the UK, we have identified the local geographic markets as corresponding to each hospital's catchment area; and
    - (iii) regardless of the precise boundaries of these geographic markets, in our local competitive assessments for central London and for individual hospitals outside central London, we have taken into account the relative strength of the competitive constraints exerted by different private hospitals/PPUs within these geographic markets. We have also considered competitive constraints

provided by private hospitals/PPUs located outside these geographic markets.

## **6. Competitive assessment: private hospital operators**

### ***Introduction***

- 6.1 In this section, we assess whether there are features of the private healthcare markets that give rise to one or more AECs through unilateral market power of private hospital operators including PPUs. This assessment addresses our ToH 1, 3 and 5 and certain aspects of ToH 7 (see paragraph 4.5).
- 6.2 As set out in paragraph 5.53(b), we have defined distinct product markets in the provision of hospital services for individual specialties and, for each specialty, separate markets for inpatient, day-patient and outpatient care. For the purposes of the assessment of competitive constraints, we have aggregated most of the specialties we have considered where we think it appropriate (see paragraph 5.54(b)).
- 6.3 As set out in paragraph 5.54(a), our analysis of competitive constraints has focused on private hospitals and PPUs providing inpatient care, as defined in paragraph 5.52(c)(ii) and (iii), or subset of these. Similarly, our analysis of barriers to entry and expansion and our profitability analysis have focused largely on providers of inpatient care.
- 6.4 We have focused on private hospitals and PPUs providing inpatient care for the following reasons. First, providers of inpatient care account for a substantial share of the revenue generated by private patients in the UK (see paragraph 5.43). Secondly, concentration is relatively higher in the provision of inpatient care than in the provision of day-patient and outpatient care. For example, according to Laing & Buisson, there were 264 day-only clinics in the UK in 2013 and most of them were relatively small clinics (see paragraph 5.47). We noted that, while providers of inpatient care compete with a wider set of providers, including day- and outpatient-only clinics, in the provision of day-patient and/or outpatient care, this is unlikely to hold across the full range of day- and outpatient treatments. In particular, certain day- and outpatient treatments (for example, those which require inpatient care as a back-up or those which are ancillary to an inpatient treatment) are likely to be subject to similar competitive conditions as those arising in the provision of inpatient treatments (see paragraph 5.48).
- 6.5 Depending on the specificity of each analysis, our analyses of competitive constraints have considered inpatient treatments and/or day- and outpatient treatments. For example, our self-pay PCA has looked at inpatient treatments, while our insured price analysis has looked at inpatient and day-patient treatments. Our profitability analysis has looked at all of the activities carried out by the hospital operators including inpatient, day-patient and/or outpatient treatments funded by private individuals, PMIs and the NHS. In what follows, we will set out the framework we have used for each of our analyses.
- 6.6 As set out in paragraph 5.70(c), we have defined local geographic markets as being central London and, for the rest of the UK, each hospital's catchment area and we have considered competitive constraints within and outside these geographic markets.
- 6.7 This section has three main subsections. In the first, we assess market structure considering barriers to entry and expansion and local competitive constraints. In the second, we consider market outcomes, namely self-pay prices, insured prices, non-price outcomes (quality and range) and profitability. Finally, in the third section we set out our conclusions.



## Structure

### *Barriers to entry and expansion—introduction*

- 6.8 Our guidance states that swift entry or expansion on a sufficient scale or the threat of entry or expansion may constrain incumbent firms.<sup>215</sup> In this section, we examine the extent to which incumbent private hospitals are constrained by the threat of entry or expansion.
- 6.9 We first set out by way of background a brief overview of entry and expansion which has occurred since the mid-2000s. We then summarize the three case studies of entry or expansion that we undertook. We next set out the evidence that we have received from parties. Finally, having regard to the framework for analysis set out in our guidance, we assess the potential barriers to entry and expansion which arise in this sector.

### *Entry and expansion since the mid-2000s*

- 6.10 The structure of the private hospital sector has undergone significant change in the last decade as a result of consolidation, expansion and new entry, through both acquisition and the creation of new hospitals.
- 6.11 As described in Section 3, Spire, the second largest hospital operator, entered the UK through the acquisition of a portfolio of hospitals from Bupa in 2007. HCA, which began providing healthcare in the UK in 1996 when it acquired a 50 per cent stake in four central London hospitals, bought out the remaining 50 per cent in 2000 and acquired three further central London hospitals. Ramsay, the fifth largest UK operator, began providing private healthcare in the UK in 2007 following the acquisition of a number of hospitals and healthcare facilities. After undergoing various changes of ownership between 1997 and 2006, BMI expanded its portfolio between 2008 and 2010, buying BMI Woodlands in Darlington, BMI Southend and three hospitals from Abbey Hospitals. Aspen, originally formed through an MBO of the Parkside in south west London<sup>216</sup> and Holly House hospitals in Essex, was acquired by the US company United Surgical Partners International (USPI) in 2000, and has since made a number of acquisitions in the UK including Highgate Hospital in north London in 2003 and the Edinburgh Clinic in 2011. Bupa acquired the Cromwell hospital in central London in 2008. BMI acquired the Fitzroy Square hospital in central London 2009.
- 6.12 The above are all examples of entry or expansion through acquisition. Only two de novo hospital operators have entered by building new private hospitals: Circle in Bath (in 2010) and the 3fivetwo Group's Kingsbridge Hospital in Northern Ireland (2011).<sup>217</sup> A third, the Kent Institute of Medicine and Surgery (KIMS), located outside Maidstone, is due to open in April 2014.<sup>218</sup> A fourth, the London International Hospital (LIH), was projected to open in 2014 but it is not clear whether this project will proceed.<sup>219</sup>
- 6.13 Over the same period, we have seen examples, but not many, of existing hospital operators opening hospitals in new areas. These include Nuffield's hospital in the

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<sup>215</sup> CC3, paragraph 175.

<sup>216</sup> Aspen created the Parkside Cancer Centre in 2003.

<sup>217</sup> Kingsbridge Hospital is located in Belfast and is the first private hospital opened by the 3fivetwo Group. It has 16 beds and offers a fairly full range of services.

<sup>218</sup> See [www.kims.org.uk/](http://www.kims.org.uk/).

<sup>219</sup> See the [LIH website](#) for a description of the developer's plans.

Vale of Glamorgan, which opened in 2010, Circle's second hospital in Reading, which opened in 2012, and Spire's Montefiore Hospital in Hove, which opened in 2013. We also identified instances of existing operators expanding locally: Spire in Edinburgh and TLC in central London, for example.

- 6.14 We noted that some NHS Trusts had contracted with private hospital operators to manage PPUs on their behalf and that private hospital operators were using these opportunities to enter new local areas or expand in areas where they already operated hospitals. These included the management by HCA of the Christie Clinic PPU in Manchester and the University College Hospital (UCH) and Guy's and St Thomas' (GST) PPUs in central London and Ramsay's successful bid to operate the Addenbrooke's Hospital PPU in Cambridge.<sup>220</sup> We understand that a number of other NHS Trusts in England are in the process of or are considering creating or expanding PPUs and tendering for private operators to manage them.<sup>221</sup>
- 6.15 In addition, we were told that hospital operators have contemplated entry but have been deterred by the risks of entry, as in the case of BMI in Edinburgh, for example, where it considered the market opportunity was insufficient; prevented from attempting entry by the difficulty of raising the necessary finance, as with Circle in Edinburgh; or, as with Spire and BMI, in central London, by the difficulty of finding a suitable site.
- 6.16 Finally, and for completeness, we note that there have been a number of failed attempts at entry or expansion through acquisition. [redacted]<sup>222</sup>, London Heart Hospital, which was bought by the DoH in 2001.<sup>223</sup>
- 6.17 All the examples cited above were for hospitals with inpatient facilities. There have also been examples of small-scale and specialist entry during this period but, as we set out below, small-scale entrants face barriers in offering a wider range of services, and particularly in an inpatient setting.
- 6.18 Examples of recent attempts at small-scale entry include: the Edinburgh Clinic (2008),<sup>224</sup> the Prospect Eye Clinic<sup>225</sup> (Altrincham, May 2009); the Cathedral Eye Clinic (Belfast, March 2008); the Midland Eye Clinic<sup>226</sup> (2012); the Hand to Elbow Clinic (Bath, 2008); Nucleus Healthcare, a gastroenterology hospital in Newport (2008); and the Cambridge Heart Clinic (2006).<sup>227</sup> However, some of these ventures failed, for example the Nucleus Healthcare Hospital which went into administration in October 2012,<sup>228</sup> and some mainly offer procedures which would not typically be covered by PMI, for example laser eye surgery.<sup>229</sup>

### *The case studies*

- 6.19 We conducted case studies in three areas where entry or expansion had been attempted. The three areas selected were Bath, central London and Edinburgh.
- 6.20 Bath provided an example of new entry by a new market entrant through new capacity being built. In Edinburgh, there had been examples of failed attempts at entry,

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<sup>220</sup> Ramsay has hospitals in the region in Hitchin, Peterborough and Colchester but not in Cambridge itself.

<sup>221</sup> See, for example, [Health Service Journal](#), 6 June 2013.

<sup>222</sup> [redacted]

<sup>223</sup> See [broadcast](#) and [press reports](#)

<sup>224</sup> Acquired by Aspen in 2011.

<sup>225</sup> Acquired by Optegra in June 2012.

<sup>226</sup> Aspen acquired a majority shareholding in the Midland Eye Clinic in 2012.

<sup>227</sup> A partnership between Cambridge University Hospitals NHS Foundation Trust and [Regent's Park Heart Clinics Ltd.](#)

<sup>228</sup> [www.bbc.co.uk/news/uk-wales-south-east-wales-20093059](http://www.bbc.co.uk/news/uk-wales-south-east-wales-20093059).

<sup>229</sup> See [www.cathedraleye.com/services/](http://www.cathedraleye.com/services/).

new small-scale entry, and expansion by an incumbent, which suggested that it would provide a good case study on expansion as well as small-scale new entry. In the case of central London, we found an example of successful expansion by a smaller operator and that several other parties had tried to enter the central London market. Our case studies are set out in full in Appendices 6.1, 6.2 and 6.3.<sup>230</sup> We summarize them below.

### *Bath*

- 6.21 In Bath, Circle built a new hospital at a cost of around £30 million on a business park 9 miles south of the city. It opened in March 2010 and was Circle's first hospital in the UK.
- 6.22 Circle told us that it faced no problems in finding the site or obtaining planning permission for its Bath hospital. Circle also told us that it had not encountered any material problems as regards CQC registration, though it said that it was required by the CQC to undertake some additional building works in the theatre and recovery areas and that these contributed to a short delay in the hospital's opening.
- 6.23 Prior to the opening of Circle Bath BMI launched a number of schemes to encourage consultants to continue practising at its Bath Clinic. However, Circle told us that its partner/consultant business model<sup>231</sup> had been effective in attracting the support of local consultants and that consultants' willingness to become partners in the hospital had been important in winning support from financial backers.
- 6.24 AXA PPP and Aviva initially chose not to recognize the new Circle hospital in Bath on their main lists for day-case and inpatient treatment. AXA PPP represented about one-quarter of the PMI market and consequently its policyholders could not have the full cost of their treatment at the Circle hospital reimbursed by their insurer. In addition, because consultants tend to be reluctant to split their work between two hospitals, Circle faced the risk that surgeons would continue to treat all patients at BMI's Bath Clinic.<sup>232</sup> Because of this, Circle chose, as a temporary measure, to treat AXA PPP customers at its own expense while continuing to try and negotiate recognition terms with AXA PPP.<sup>233</sup> Circle did the same with Aviva patients, though the cost of doing so was lower than in the case of AXA PPP since fewer patients were insured with Aviva than AXA PPP, and Aviva made a contribution to the cost of its policyholders' treatment at hospitals not recognized on its main network whereas AXA PPP did not.
- 6.25 Circle told us that AXA PPP's, and to a lesser extent Aviva's, decision not to recognize the Circle Bath facility had negatively impacted its profitability by forcing it to treat the patients concerned at its own expense and that, as a result, the facility would become profitable later than originally anticipated.
- 6.26 We found that AXA PPP had declined to recognize Circle Bath even though it would have been slightly better off financially if it had done so. AXA PPP told us that its decision was taken in the context of its broader, national, relationship with BMI,

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<sup>230</sup> [www.competition-commission.org.uk/our-work/directory-of-all-inquiries/private-healthcare-market-investigation/analysis/working-papers](http://www.competition-commission.org.uk/our-work/directory-of-all-inquiries/private-healthcare-market-investigation/analysis/working-papers).

<sup>231</sup> See Appendix 6.1 for a description of Circle's business model.

<sup>232</sup> The unwillingness of consultants to undertake significant amounts of private work at more than one hospital is sometimes referred to as 'consultant drag.'

<sup>233</sup> This allowed Circle to attract consultants to do their full surgical lists at the hospital, with Circle only forgoing payment on AXA PPP patients.

including the need to secure agreement over BMI's participation in AXA PPP's Corporate Pathways product.

- 6.27 The outcome in Bath was that Circle succeeded in taking roughly half of local private hospital expenditure, although its performance was below that forecast in its original plans for the business and its dependence on NHS revenue has been higher than originally foreseen. However, Circle Bath had to bear the cost of treating AXA PPP patients itself for over a year as a result of the lack of full recognition and in order to encourage consultants to treat patients funded by other insurers to work at its hospital and is still losing money.

### *London*

- 6.28 In London, an existing operator, TLC, wished to expand its oncology facilities to create a dedicated cancer treatment centre close to its main hospital in the Harley Street area. The cost of acquiring the site for the Cancer Centre and of building and equipping it was approximately £90 million.
- 6.29 The Cancer Centre opened in 2009. Finding a suitable site and obtaining the necessary permissions to build it took [X] years. This entailed negotiating a complex Town Planning Class use swap for the, then residential, 23 Devonshire Place which, had it not been accomplished, would have required work on the Cancer Centre to cease.<sup>234</sup> The use swap involved the assembly of a package of premises to provide additional residential accommodation at 11 Devonshire Place, 4 Marylebone Mews, 59 Wimpole St and 92 New Cavendish Street to replace some of that lost at 23 Devonshire Place. Subsequently the remaining residential accommodation was created, at 50 Hallam Street.<sup>235</sup>
- 6.30 TLC told us that it had not encountered any material problems with obtaining other regulatory permissions or recognitions, for example CQC registration.
- 6.31 TLC told us that it had encountered difficulties in retaining key oncologists. It had had a cooperation agreement with the London Oncology Clinic (LOC)<sup>236</sup> but this expired and the LOC was acquired by HCA. TLC told us that it had been necessary to offer a small number of consultants large financial incentives to retain their practice at TLC.
- 6.32 AXA PPP recognized the Cancer Centre almost immediately, despite attempts by HCA to persuade it not to include additional radiotherapy facilities in its network in London. TLC is now available to clients of AXA PPP's Corporate Pathways product whereas HCA facilities are not. TLC encountered no difficulties with Bupa, Aviva or PruHealth as regards recognition.
- 6.33 We found that while TLC had been successful in expanding in central London it had encountered difficulties and delays in doing so, the main ones being identifying, acquiring and obtaining permissions for a suitable site and retaining and attracting oncologists to practise at its clinic. As a result, [X].

### *Edinburgh*

- 6.34 Prior to 2009, there was a single private hospital in Edinburgh, Spire Murrayfield, located on Corstorphine Hill to the west of the city centre. Several private hospital

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<sup>234</sup> Final conditions for the use swap were set out in the City of Westminster Planning Committee [report](#) on the development.

<sup>235</sup> See [City of Westminster Planning Committee report](#).

<sup>236</sup> Subsequently renamed Leaders in Oncology Care.

operators identified an opportunity to enter or expand in Edinburgh based on three main factors. First, there are around 40,000 people with PMI in Edinburgh. Second, several parties told us that Edinburgh was underserved by private facilities and that the Murrayfield hospital was capacity constrained. Third, following the move of the Royal Infirmary of Edinburgh to a new site to the south-east of the city centre, there was an opportunity for an entrant to provide facilities close to the new hospital.

- 6.35 Circle sought to commence offering services in Edinburgh in 2008/09 with a hospital located in close proximity to the relocated Royal Infirmary of Edinburgh. However, despite achieving its target level of consultant revenue commitments and acquiring a suitable site with planning permission for a hospital, it was unable to secure the necessary funding to build the hospital.<sup>237</sup> Circle's prospective entry, together with the broader market opportunity, prompted Spire to expand in Edinburgh with its Shawfair Hospital. Spire built the new day-case facility near the new site of the Edinburgh Royal Infirmary at a total cost of around £[redacted] million. Spire concluded that, following the completion of this hospital, it was unlikely that Circle or any other competitor would seek entry.
- 6.36 The Edinburgh Clinic, which entered the city on a smaller scale, was able to acquire and convert an existing building in the Morningside area (south-west of the centre). This facility, which opened in 2008, focused initially on offering outpatient consulting rooms, minor treatments and diagnostic facilities, although it has developed its service offering to cover a range of day-case procedures.
- 6.37 Aspen, which acquired The Edinburgh Clinic, told us that small-scale entry into the inpatient market, for example with five overnight beds, was not viable due to the costs of staffing a facility 24 hours a day. Hence, for an entrant to compete successfully for inpatient work, it would need to invest more heavily in facilities and staff to be able to capture significant patient volumes.
- 6.38 Dr Errington, previous owner and founder of The Edinburgh Clinic, told us that AXA PPP decided not to recognize it other than for outpatient treatment and that this initially impeded its expansion into areas of treatment requiring day-case or inpatient care. In contrast, an agreement with the NHS to provide minor surgical and diagnostic procedures to publicly-funded patients served to increase volumes and raise the profile of the facility among local GPs and consultants.
- 6.39 BMI considered entering Edinburgh by building a hospital but was deterred from doing so because of the limited revenue available and its view that it would need to capture around [redacted] per cent of Spire's share, or grow the market significantly, in order to enter profitably. [redacted]
- 6.40 We found that, whilst there had been examples of both successful entry and expansion in Edinburgh, attempts at new entry were deterred by a combination of the size of the local market and the economies of scale involved in operating a hospital. Entry appears to have been made more difficult by the incumbent increasing its capacity in the market. In contrast, we found that obtaining suitable sites in terms of both location and planning permission was relatively straightforward in Edinburgh and hence did not pose a barrier to entry. The experience of The Edinburgh Clinic demonstrated that niche entry, for example with a day-case clinic, can be successful but this does not appear to constrain incumbent hospitals with inpatient facilities.

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<sup>237</sup> Circle's attempt to raise funding in Edinburgh took place in 2009, coinciding with the financial crisis. We would expect funding to be more readily available under more normal market conditions.

- 6.41 Spire's expansion has increased the range of private medical services offered to patients in Edinburgh, particularly in terms of IVF, oncology and cardiology. However, this expansion also appears to have deterred the entry of rival hospital operators which could have been expected to put downward pressure on prices.

### *Assessment of barriers to entry or expansion*

- 6.42 We considered the following as potential barriers to entry and assessed each in turn:

- (a) costs of entry;
- (b) healthcare regulation;
- (c) site availability;
- (d) planning regulations;
- (e) strategic barriers:
  - (i) PMI recognition; and
  - (ii) clinician incentives.

### *Costs of entry*

- 6.43 The cost of designing, building and equipping a private hospital to provide inpatient, day-case and outpatient services across a wide range of specialisms is high and, more important, most of this cost is sunk.
- 6.44 Circle's Bath hospital cost approximately £30 million. TLC's new cancer centre cost approximately £90 million. Spire's Montefiore Hospital cost £35 million. The KIMS hospital and medical centre outside Maidstone cost around £85 million.
- 6.45 The hospital operator's ability to recoup these costs in the event that attempted entry is unsuccessful, however, is generally very limited. The options are realistically confined to selling the facility to another hospital operator or converting the building to, for example, hotel, residential or commercial use. Where a change of use was envisaged, this would be likely to entail significant reconfiguration of the hospital building since it would comprise, for example, a large number of single bedrooms, small consulting and treatment rooms and operating theatres with specially designed air-handling systems. The location of the hospital would also have a bearing on its use value other than as a hospital: a hospital on an industrial park (as with Circle Bath) or on a greenfield site (as with KIMS) could be harder to dispose of than a town centre building.
- 6.46 [✂]

FIGURE 6.1

### **BMI presentation to funders**

[✂]

Source: BMI.

- 6.47 In addition, the prospects of failure are increased and the potential rewards of success are reduced as a result of overcapacity in the industry, particularly for inpatient services, [REDACTED], and the long lead time, usually at least two years, associated with a new hospital launch. These two factors provide incumbent operators with the incentive and the ability to prepare and execute a robust response, as we saw in Bath and in Edinburgh.
- 6.48 A presentation submitted by Nuffield similarly acknowledges the barriers to entry of high capital costs and long lead times required to develop new hospitals, as does a report to Spire by Colliers GRE which refers to the ‘considerable barriers to entry’ in the sector.
- 6.49 In many areas of the UK an efficiently-sized new private hospital would be relatively large compared with the size of the local area, which may only be large enough to support a relatively small number, and perhaps only one, efficiently-sized private hospital. As a consequence, [REDACTED], new entry may result in an outcome where both the entrant and the incumbent [REDACTED].<sup>238</sup>
- 6.50 Although private hospitals, in England at least, have increasingly generated revenue from the treatment of NHS patients, this has barely compensated for the reduction in PMI revenue, giving rise to excess capacity within the private hospital sector.<sup>239</sup> As a result, unless there is substantial unsatisfied local demand or the local market is growing, if a new hospital enters it will only be successful if it attracts substantial business from the incumbent. This provides a further and powerful incentive to the incumbent to deter or defeat an entrant.
- 6.51 In other industry sectors, a firm might seek to enter the market on a small scale and then, having established a foothold, gradually expand. However, there are economies of scale associated with private hospitals. Because of the need to provide the staff and facilities necessary to offer a wide range of specialisms and care on a 24/7 basis, a hospital business will have a high level of fixed costs. The business will therefore need to attract a high volume of inpatients in order to cover these fixed costs and, as a result, small-scale entry with, for example, a limited amount of overnight accommodation is unlikely to be profitable. Aspen, for example, told us that its current site in Edinburgh was not suitable to develop into a fully-functioning inpatient facility since, with just five bedrooms, it would have insufficient capacity. The same factors would apply to a clinic offering only day-case services: provision of inpatient services would not be viable without incurring significant additional fixed costs. For these reasons, we concluded that small-scale general hospitals are unlikely to be profitable.
- 6.52 BMI disagreed with this analysis. It told us that while there was a minimum efficient scale for a private hospital offering inpatient services, it was not particularly large. It gave as examples five BMI hospitals with a single operating theatre but which offered a full range of services, including inpatient care. These were: Carrick Glen, Foscoate, Lancaster, Sefton and Werndale.
- 6.53 However, we considered that the examples chosen suggested that smaller private hospitals might struggle to operate profitably. We noted that [REDACTED].<sup>240</sup>

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<sup>238</sup> [REDACTED]

<sup>239</sup> Private Acute Medical Care 2013, Laing and Buisson, p13.

<sup>240</sup> In 2011, BMI attempted to sell the Carrick Glen hospital as part of Undertakings in Lieu given to the OFT arising from BMI's acquisition of four Abbey hospitals and the finding of an SLC in the local market around Carrick Glen. In the event, the business proved unsaleable and BMI was [released from its Undertakings by the OFT](#).



6.54 HCA submitted that the barriers to entry identified by the CC, including the high and sunk costs of building a new hospital, did not constitute a barrier to entry in London. It cited as evidence examples of expansion in London including the investment in TLC's Cancer Centre, the expansion of King Edward VII's Hospital, Aspen's expansion of its Highgate Hospital and of expected developments, for example the LIH. In addition, it pointed out that the London healthcare market was growing and said that it was forecast to continue growing.<sup>241</sup>

6.55 We acknowledged that expenditure on acute private medical care services in London was large (see Appendix 6.10, Central London) and had been growing.<sup>242</sup> Nonetheless, no new hospital had opened in central London in the last five years, and in the one case where a new hospital opening was in prospect, the [X].

- *Conclusions on costs of entry*

6.56 We concluded that the high sunk cost of launching a new private hospital made entry or expansion on a scale likely to constrain an incumbent unlikely in local markets areas since, generally, demand was relatively limited and/or not growing. We concluded that in many local areas there was not currently, nor was there the prospect of in the near future, sufficient private patient revenue to sustain two private hospitals profitably and that this would, particularly when combined with the high sunk costs concerned, be a strong deterrent to entry. We concluded that the scale economies associated with the operation of a general private hospital were present in all local markets and thus precluded efficient entry on a small scale.

*The regulation of healthcare facilities*

6.57 The regulatory framework that applies to healthcare facilities is described in Section 2.

6.58 None of the main hospital groups that had opened new facilities reported any problems with obtaining approval for these from the relevant regulator.

6.59 Circle, in Bath, and TLC told us that they had not encountered any material problems as regard CQC registration, though Circle said that it was required by the CQC to undertake some additional building works in the theatre and recovery areas and that these contributed to a short delay in the hospital's opening.

- *Conclusions on healthcare regulation*

6.60 In light of the evidence we received, we did not consider that the various healthcare regulatory requirements constituted a barrier to entry or expansion.

*Site availability*

6.61 Site availability was not identified as an issue in the Bath or Edinburgh case studies. In Edinburgh, Circle as well as Spire was able to locate and acquire suitable sites. Similarly, in relation to other new developments including Circle Reading, Spire Montefiore, KIMS and HCA in Manchester<sup>243</sup> availability of suitable sites does not

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<sup>241</sup> [HCA response to provisional findings](#), Section 6.

<sup>242</sup> See revenue growth for London hospital operators. Private Acute Medical Care, 2013, Laing and Buisson, p46 and [Annual Report and Accounts of King Edward VII Hospital, 2012](#).

<sup>243</sup> The Christie Clinic and the new PPU planned for the Medipark in south Manchester.



appear to have been a barrier to entry. However, we received many representations that site availability in central London constituted a barrier to entry (see below). We considered the evidence gathered in the course of researching our case studies and that submitted in response to the provisional findings. We set out first the responses that we received regarding site availability outside central London.

- *Outside central London*

- 6.62 BMI, the only hospital group other than HCA to comment on this aspect of our findings, said that although it agreed with the CC regarding site availability in central London in the W1 area surrounding Harley Street, the CC had offered no evidence of scarcity of sites outside central London.<sup>244</sup> Further, it said that the CC's land valuation exercise had identified a large number of alternative sites to the current hospital sites it looked at.<sup>245</sup> [✂]

- *Central London*

- 6.63 HCA disagreed that site availability was a barrier to entry or expansion in London. It told us that considerable new entry and expansion had taken place in London in recent years, citing as examples TLC's Cancer Centre (2009), the projected expansion of the King Edward VII's Hospital, BMI's acquisition of the Fitzroy Square Hospital (2009) and Aspen's development of the Parkside Cancer Centre in Wimbledon (2003).<sup>246</sup>
- 6.64 HCA said that there was 'concrete evidence' of further planned entry in London and gave as an example the LIH, which was intended to operate on the site of the former Royal Masonic Hospital in Ravenscourt Park, west London, and expected to open in 2014. It described the LIH as a 150-bed facility which will offer sophisticated, tertiary services.<sup>247</sup>
- 6.65 HCA told us that there was a range of NHS sites available that could be used by new and existing hospital operators and submitted a report that it had commissioned from McKinsey and Co on the likely availability of NHS sites.<sup>248</sup> The report stated that [✂]. These included the Heart Hospital, 16–18 Westmoreland Street, in central London which HCA said was currently being marketed to prospective private hospital developers. It said that acquisition of this facility would quickly enable a prospective entrant to invest in an existing 70-bed hospital which would represent a formidable competitor in central London.<sup>249</sup>
- 6.66 It told us that Spire had publicly announced its intention to invest in London and that it was seeking to develop a hospital with eight to ten operating theatres and around 100 bedrooms.<sup>250</sup> It cited as a further example of new entry the KIMS hospital, also scheduled to open in 2014.<sup>251</sup> In addition, it told us that Ramsay was involved in a development together with Cambridge University Hospitals Trust and John Laing Infrastructure to launch a £120 million new hospital and research facility.<sup>252</sup>

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<sup>244</sup> BMI response to provisional findings, Annex 5, paragraph 3.22.

<sup>245</sup> *ibid*, Annex 5, paragraph 3.23.

<sup>246</sup> HCA response to provisional findings, paragraph 6.4.

<sup>247</sup> *ibid*, paragraph 6.6.

<sup>248</sup> This stated that the Heart Hospital site would be available for sale by the end of 2014.

<sup>249</sup> HCA response to provisional findings, paragraph 6.64ff

<sup>250</sup> *ibid*, paragraph 6.10.

<sup>251</sup> *ibid*, paragraph 6.11ff.

<sup>252</sup> *ibid*, paragraph 6.17.

- 6.67 Finally, HCA provided us with a list of sites in central London which it said were potentially available for development as private hospitals.<sup>253</sup> [§]<sup>254</sup> in the West End of London whose owners, it told us, were considering whether the site could be developed as a private hospital, and [§] in the Holborn area.<sup>255</sup> HCA also provided us with a general statement, prepared by Altus Edwin Hill, regarding the availability of premises in central London for acute healthcare purposes.<sup>256</sup> The statement included a list of sites ranging from 30,000 to 50,000 square feet in size that were available and suitable for new hospital developments. In that report, Altus Edwin Hill stated that ‘in each case the owners have indicated that they would accept in principle the accommodation being let for private acute care use and that planning permission could be obtained’. The report noted that a ‘full search would almost certainly yield more opportunities’. During a hearing with the CC, HCA provided us with a folder of marketing material for sites which were currently available and which would be suitable for redevelopment as healthcare facilities and told us that it had recently signed a lease of space at the Shard and that the same opportunity would have been available to others.
- 6.68 We considered each of these points in turn.
- 6.69 As regards previous and recent entry or expansion, we acknowledged that the creation of the TLC Cancer Centre constituted market expansion but, as we pointed out in our case study, it took TLC 3½ years to undertake the project, including assembling and appropriately configuring the properties that enabled it to build the Centre. Similarly, the planned expansion of the King Edward VII’s Hospital with the creation of up to 40,000 sq feet<sup>257</sup> of additional space was confirmed to us though it will be four to five years before these additional facilities are open.
- 6.70 We note that our guidance refers to the prospect of entry and expansion ‘within a short time’ which can sometimes countervail against an AEC decision.<sup>258</sup> All of the major hospital extensions or new build projects that we have examined in central London have had lead times of several years. Consequently, even if sites were available it is unlikely that entry or expansion could take place within the ‘short time’ referred to in our guidance.
- 6.71 With regard to its purchase of healthcare facilities in London, BMI told us that central London posed unique difficulties for hospital operators in terms of barriers to entering the market. [§]<sup>259</sup> BMI told us that had a strong desire to increase its presence in the central London market. However, under its current financing structures, it was unlikely that BMI could deploy the capital to move significantly into central London in the next three or four years.<sup>260</sup>
- 6.72 We did not consider Aspen’s development of its Cancer Centre 11 years ago to be a recent example of site availability in central London as it is located in Wimbledon and thus outside of the area bounded by the North and South Circular Roads on which we based our definition of central London.

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<sup>253</sup> *ibid*, paragraph 6.62 ff.

<sup>254</sup> HCA had also told us that Howard de Walden Estates had plans to create space for a 100-bed hospital on Cavendish Square ([HCA annotated issues response](#), paragraph 7.7). It is not clear if this was the project to which HCA was subsequently referring.

<sup>255</sup> [HCA response to provisional findings](#), 6.71.

<sup>256</sup> Exhibit 3 to [HCA response to provisional findings](#).

<sup>257</sup> 3700 square metres.

<sup>258</sup> CC3, [paragraph 203](#).

<sup>259</sup> [§]

<sup>260</sup> [BMI hearing summary](#), 27 March 2013.

- 6.73 We next considered the example of future entry provided by HCA, starting with the LIH. We contacted the developers of the LIH, C&C Alpha Group,<sup>261</sup> and also visited the site, in early 2014. From our visit it was evident that work on refitting and re-furbishing the hospital was not under way and it therefore seemed extremely unlikely that the LIH could open during 2014. The developers, who had acquired the building in 2007, confirmed that the work necessary to refit the building as a modern working hospital was suspended pending agreement of a £[redacted] million financing package to take the project forwards. C&C Alpha Group told us that it was hard to find a hospital site in London. It said that the Ravenscourt Park hospital site represented the minimum size (around 190,000 square feet)<sup>262</sup> sufficient to provide the necessary 150 beds for a viable hospital, absent the NHS choosing to sell some of its sites and those being obtained for medical rather than residential use.
- 6.74 HCA had told us that the Heart Hospital, 16-18 Westmoreland Street, in central London was currently being marketed to prospective private hospital developers. We contacted the UCLH trust, which is responsible for the hospital, and asked it what its plans were for the property. It told us that in common with many other Foundation Trusts it was reviewing its entire property base, but that no formal decision had yet been taken as to the future of the hospital by its Board. It told us that it would continue to use the site in the near to medium term and had no immediate plans to commence disposal of the site.
- 6.75 HCA had also told us that the Western Eye Hospital site on Marylebone Road was likely to become available. We asked the Imperial College Healthcare Trust to confirm that this was the case. It told us that it intended to dispose of the Western Eye Hospital site on Marylebone Road and relocate services to the main St Mary's Hospital site nearby. It said that it envisaged that the property would be likely to be released in 2018/19. As with other NHS former hospital sites, it is not certain that the site would remain as a hospital as other uses, for example housing, may be considered more attractive.<sup>263</sup>
- 6.76 We asked Spire whether it was likely that it would, as suggested by HCA, enter the central London market in the near future. [redacted]<sup>264</sup>
- 6.77 We did not consider that either the Ramsay hospital development in Cambridge or KIMS in Maidstone was informative as regards ease of entry in the central London healthcare market.
- 6.78 While we considered it possible that some patients, individually, might, depending on where they lived, consider these hospitals as alternatives to one of HCA's, we regarded it as implausible that a PMI would consider either of these hospitals outside London as substitutes to HCA facilities to the extent that they could decline to recognize, say, the London Bridge Hospital, and instead direct patients to KIMS.
- 6.79 AXA PPP told us that patients residing in central London did not travel out of London for treatment but the reverse was true. It said that some of its members who lived near London might travel into central London for treatment but it did not anticipate that the opening of KIMS would change this flow such that patients from, say, Tunbridge Wells, who would have previously had treatment at London Bridge, would now attend KIMS.

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<sup>261</sup> See [www.ccalphagroup.co.uk/](http://www.ccalphagroup.co.uk/).

<sup>262</sup> 17650 square metres.

<sup>263</sup> See, for example, Disposal Strategy, [Land for Housing, DH and NHS](#), October 2011, and [plans for RNOH land](#).

<sup>264</sup> Spire told us that it required a site of approximately [redacted] square feet ([redacted] square metres) and that there were very few available.

- 6.80 AXA PPP told us that corporate clients would be likely to react similarly. It said that it did not believe any corporate scheme would delist an inner London HCA hospital and represent to a FTSE 100 company that KIMS or Addenbrooke's PPU could be a realistic substitute. KIMS and Addenbrooke's PPU would add a peripheral choice to the London market but would not provide material substitution.
- 6.81 Bupa said that the two facilities concerned would not be seen as substitutes to central London facilities by a sufficient number of customers, particularly corporate customers, for them to exert any material constraint on HCA in central London.
- 6.82 We next considered some of the sites that HCA had told us were potentially available for private acute healthcare purposes. We noted that the marketing material for one, Harcourt house, stressed the site's potential for residential development, pointing out that loss of medical use of some parts of the building may be acceptable and that residential is the priority land use there.<sup>265</sup> Africa House, another building listed, had already been developed and was being marketed for headquarters office use.<sup>266</sup> We next considered evidence arising from HCA's own attempts to identify sites suitable for hospital use in central London that were currently being used for other purposes.
- 6.83 We reviewed papers which HCA had submitted to Southwark Council in support of the planning application<sup>267</sup> to convert three floors of the Shard to medical use. In his letter in support of the application, the CEO of the London Bridge Hospital said that it was at full capacity and that the need for additional capacity continued to grow. He said that the London Bridge Hospital had looked at occupying floor space in the near vicinity and reported that there was a shortage of suitable space. He attached a report from the hospital's agents which it said demonstrated the lack of suitable vacant floor space (both office and medical space) locally. It concluded that there was no suitable space to meet its expanding needs.
- 6.84 The report from the agents began by stating that it had been engaged in a search for suitable expansion space for HCA for in excess of 14 months and that it understood that another agent had been conducting a similar search prior to its involvement. It explained the criteria that it had employed in its search, which encompassed the whole of the London Borough of Southwark, noting that because of the expensive fit-out that HCA would require, because of its business, short-term leases were of little use. It also said that there was a 'critical mass' due to these fit-out costs which gave rise to a minimum size requirement to make the property economic for HCA's needs. It said that as a rule of thumb it worked on a minimum size of 5,000 sq ft and its search had encompassed premises from this size to 250,000 sq ft<sup>268</sup>.
- 6.85 It found 37 locations which met its criteria, none of which were currently subject to a C2 consent.<sup>269</sup> It therefore supplied details of sites with B1 consent<sup>270</sup> where it said that a change of use could be secured. Fourteen of these were inappropriately located, 13 had floor plates which were too small for HCA and 5 were either freehold or short leases. It concluded that the only suitable premises were those at the Shard, the subject of the planning application.<sup>271</sup> HCA received planning permission for the change of use in late 2013.<sup>272</sup>

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<sup>265</sup> See [www.harcourthousew1.com/TR\\_Harcourt\\_House.pdf](http://www.harcourthousew1.com/TR_Harcourt_House.pdf).

<sup>266</sup> See <http://africahousew2.com/dl/brochure.pdf>.

<sup>267</sup> HCA told us that the planning application was submitted jointly with the landlord of the Shard, Teighmore Limited.

<sup>268</sup> Equivalent to between about 500 to 23250 square metres.

<sup>269</sup> Class C2 permits use for 'residential institutions' which would include hospitals with inpatient (overnight) facilities.

<sup>270</sup> Class B1 permits business, for example office, use.

<sup>271</sup> Appendix 1 to Planning Statement.

<sup>272</sup> See [Southwark planning register](#).

- 6.86 We noted that while HCA might have preferred a site adjacent to the London Bridge Hospital, its difficulties in identifying a suitable site did not stem from an insistence that the site be located close to its existing site, as it had suggested.<sup>273</sup> Instead, its agents were instructed to search for premises throughout the London Borough of Southwark.
- 6.87 Finally, HCA told us that the opportunity presented by the space at the Shard had been available to any other hospital operators. We note however that HCA's application for planning permission<sup>274</sup> was made on a 'personal' basis such that if the premises were leased to a company other than HCA its use classification would revert to B1.<sup>275</sup> The case officer's report on the application referred to the 'exceptional circumstances' of HCA in that it operated the nearby London Bridge hospital and had links with the Guy's and St Thomas' trust and that this justified the granting of the permission on a 'personal' basis to HCA. The report noted that since it was a personal planning permission 'any other healthcare/medical facilities operators wishing to occupy these levels would not be permitted.'<sup>276</sup> It is therefore not the case that this same opportunity was available to another hospital operator. In addition, even though it was given consent to a change of use to C2, HCA's plans submitted as part of its application were for diagnostic testing (specifically, imaging), consulting rooms and office accommodation rather than overnight accommodation, operating theatres or other treatment facilities. HCA already has such facilities in the area, at its London Bridge Hospital, and will, in 2016, have them in the nearby Guy's and St Thomas' PPU within the new Cancer Centre. It is therefore also not clear whether the space in the Shard is physically suitable for use as a hospital, for example as regards the air-handling requirements of operating theatres and thus whether another hospital operator, without complementary treatment facilities nearby, could operate the space in the Shard as a stand-alone facility, capable of competitively constraining HCA.

- *Conclusions on site availability*

- 6.88 We found some, but not many, examples of new hospitals being built outside London and the developers of those hospitals told us that they had not encountered problems in identifying suitable sites. We concluded that site availability for the purposes of building a hospital outside central London was not a barrier to entry.
- 6.89 We found no examples of new hospital openings in central London and few instances of expansion. Examples of expansion that we found had taken several years from planning to opening. All the parties who expressed a view on this, with the exception of HCA, told us that finding an appropriate site for a hospital in central London was very difficult. Because of the special circumstances of the case, we did not consider that the consent to the change of use at the Shard vitiated this general conclusion on site availability in central London.
- 6.90 We concluded that the non-availability within a short time of sites that were of sufficient size and suitably configured, or capable of adaptation, for use as a hospital offering a broad range of specialisms and inpatient facilities was a barrier to entry in central London.

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<sup>273</sup> HCA suggested that where a hospital operator required a site adjacent to its existing facilities, as did TLC, it was likely that it would prove more difficult to find suitable premises than if was willing to accept a site further afield.

<sup>274</sup> HCA told us that the application was made jointly with the landlord of the Shard and that it was not unusual for a landlord in this situation to seek consent which is linked to the duration of the tenant's lease so that when the tenancy comes to an end the landlord retains the flexibility to relet the space for alternative uses, in this case office use (email 13 March 2014).

<sup>275</sup> See [Reasons for Decision](#).

<sup>276</sup> Case officer report, Proposal 13/AP/3322.



## *Planning regulations*

- 6.91 We received submissions from a number of private hospital operators on the extent to which planning regulations constituted a barrier to entry. We first set out submissions concerning the impact of planning regulations outside central London.

- *Outside central London*

- 6.92 Circle told us that the planning process was identified early on as a significant barrier for its development programme. It said that with no allocations for hospitals/medical facilities in local plans, the default position of local authorities had been to require the applicant to demonstrate ‘need’<sup>277</sup> for new medical facilities to override existing land use policy. Circle also explained that it had had to work closely with local authorities to guide them through unfamiliar territory when assessing healthcare ‘need’. In particular, it told us, in the absence of government guidance to local authorities it had been necessary to persuade both officers and planning committee members that many of the views of local hospital trusts (and incumbent private hospital providers) should be seen as partial. It said that such objections should be regarded in the same way that one would view an objection by one supermarket operator that there was no need for a rival to establish itself in the area.
- 6.93 Circle told us that it faced no problems in obtaining planning permission for its hospital in Bath. It did, however, contrast the ease of obtaining planning permission for its new-build hospital in Bath with a similar development in Southampton which was taken to appeal, and in Warwick, where it came close to having planning permission refused.
- 6.94 Circle told us that in Southampton it faced opposition from three incumbent private hospitals and the Southampton University Hospital Trust (articulated, it said, through the Test Valley Borough Council).
- 6.95 The appeal over the refusal of planning permission for its proposed hospital at Adanac Park culminated in a two-week planning inquiry. The arguments put forward at the inquiry centred on whether the current allocation of the site for ‘employment use’ would or should be changed by the proposal, whether the hospital might impact negatively on NHS healthcare and whether there was a ‘need’ for the new hospital given existing hospital capacity (NHS and private). The Inspector considered but dismissed arguments that the proposed hospital would affect local NHS provision. He said that clinicians who had given evidence to the inquiry had said that Circle’s presence would not reduce their NHS commitments, and while the proposed hospital might give rise to some difficulty in filling radiographer positions, for example, this did not constitute an insurmountable problem. Finding in favour of Circle, he concluded that ‘there is good reason to believe that the proposed hospital would be an important addition for meeting existing and future healthcare needs in South Hampshire’.<sup>278</sup>
- 6.96 Circle told us that Nuffield and Warwick NHS Hospital were very nearly successful in preventing Circle from obtaining planning permission for its hospital at Tournament Fields. Tournament Fields had been allocated for ‘employment use’ in the local plan. As hospitals do not qualify as employment use, Warwick Council required need for a new hospital to be demonstrated. Circle told us that the Chief Executive of Warwick NHS Hospital wrote to the head of planning, stating that the Circle hospital would

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<sup>277</sup> ‘Need’ has a specific meaning in the planning context. In this case the applicants were required to identify local demand that was not served by existing healthcare facilities.

<sup>278</sup> [Appeal decision, November 2011](#), Reference APP/C1760/A/11/2152433.

undermine the viability of his hospital as Circle planned to treat NHS patients under Choose and Book. In the letter, Warwick NHS Hospital said that it did not think that there was a need for additional healthcare capacity in the area. Circle said that, in parallel, the Chief Executive of Nuffield encouraged opposition to Circle's plans through the local press and MP. Warwick District Council commissioned research from consultants which concluded that the presence of a Circle facility would not undermine the NHS hospital but would increase capacity and thus choice for both private and NHS patients. On this basis, Circle's application went to the Planning Committee with a Council recommendation to approve and the application was granted, albeit after a close vote.

- 6.97 While Circle has had more recent experience of developing new hospital facilities than the major hospital operators, we observed some instances of the larger groups deciding to open new hospitals. These included Spire's hospitals in Brighton (Montefiore) and Edinburgh (Shawfair, a day-care facility), both of which did proceed to implementation, and BMI's in Edinburgh, which did not. Neither BMI nor Spire told us that it had faced any significant planning problems outside central London. Similarly, HCA and Ramsay both told us that they had not encountered planning problems in the development of new facilities. Nuffield told us that its plans for a £[£] million refurbishment of its Chesterfield hospital in Bristol had been delayed following objections from English Heritage on listed building and conservation grounds. Planning permission was subsequently granted but with a number of conditions, including a BREAM energy assessment. It said that these factors had delayed the project and raised its cost but it had proceeded with it.
- 6.98 BMI said that the CC's assessment of planning regulations as a barrier to entry presented a mixed picture of planning experiences. It said that some, such as Circle Bath, were very straightforward whereas others were more complex, but that there was no evidence of a consistent refusal to grant planning permission, or even persistent local resistance to private hospital development. Further, BMI said that the CC's conclusion in its profitability analysis was that £250,000 should be added to the value of alternative sites for obtaining planning consent and that this represented the upper end of expected costs. BMI said that, expressed as a percentage of typical recent entry costs, this sum could not represent a high barrier to overcome.<sup>279</sup>

- *Central London*

- 6.99 HCA told us that it had submitted several examples of where it had successfully obtained planning permission for its own healthcare developments.<sup>280</sup>
- 6.100 For example, it told us that it did not encounter any difficulties in obtaining planning permission for its 2011/12 development on Devonshire Street, the site of its Harley Street Diagnostic Centre, despite the need to convert offices and residential accommodation to medical use. It said that to offset the loss of residential space, planning consent was linked to nearby developments to convert office space into residential accommodation. HCA also submitted a paper setting out the views of Howard de Walden on site availability in the Harley Street area, including the impact of planning restrictions. In the particular context of use swaps (for example, between residential and medical use), HCA told us that it was Howard de Walden's view that a new entrant would have the same ability as an incumbent to arrange these, either by

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<sup>279</sup> BMI response to provisional findings, paragraph 3.24.

<sup>280</sup> HCA response to provisional findings, paragraphs 6.74–6.75; HCA response to TLC case study working paper, paragraphs 21–25; HCA response to issues statement, section 14.

converting part of the development to retain a proportion of residential use or by buying additional space elsewhere and converting this to residential use.

- 6.101 HCA also cited the example of the change of use it secured to enable it to develop the Wellington hospital's Platinum Medical Centre (PMC) for diagnostic and day-case treatments. Here, as part of a major expansion of the Wellington hospital,<sup>281</sup> HCA was granted consent for change of use from office to medical (D1) use, excluding overnight accommodation.<sup>282</sup> Located in St John's Wood, close to the Wellington hospital, the PMC is outside the Harley Street Special Policy Area and subject to somewhat looser planning control than premises in Harley Street itself. The planning decision also noted that the site was close to the Wellington hospital and that finding an alternative site of suitable size and servicing capability elsewhere in Westminster is considered to be unlikely and would have obvious transport and servicing implications.
- 6.102 HCA submitted a table listing a series of planning decisions by London's planning authorities in favour of medical use developments, which it said demonstrated that planning decisions in favour of healthcare provision were a common occurrence in London.<sup>283</sup>
- 6.103 TLC told us that the process of acquiring the land and obtaining planning permission for its Cancer Centre took [X] years and [X] year respectively, entailing use swaps with other premises, and cost £[X] million. It said that this process was facilitated by TLC's existing presence in the Harley Street vicinity, its reputation and its relationship with landlords which a new entrant would not have.<sup>284</sup>
- 6.104 We asked Howard de Walden what restrictions if any a developer would face in seeking to change the use of premises in and around Harley Street. It told us that the residential protection planning policy led to problems in producing bigger medical units in the Harley Street area. It said that the only way to overcome this was with 'use swaps' which could be used to overcome planning restrictions on medical and residential use provided there was no overall meaningful loss of either use but which substantially increased the scope and cost of such developments. It said that this made the development and rationalization of buildings tortuous and meant that only landlords with a number of properties could realistically employ use swaps.

- *Conclusions on planning regulations*

- 6.105 The evidence from the small number of instances of expansion that have taken place indicated that difficulties in obtaining planning permission tended to centre around applications for change of use. This was particularly evident in the Special Policy Area around Harley Street. Where an expansion of medical facilities would reduce residential accommodation it would be necessary to arrange use swaps, which we considered it would be difficult for an entrant to execute.<sup>285</sup> Because of the special circumstances of the case, as noted above (paragraph 6.89), we did not consider that the granting of consent for a change of use of three floors of the Shard from B1 to C2 altered our general conclusion on the difficulty of obtaining planning permission for new hospitals in central London. In the case of planning applications outside London, difficulties in obtaining planning permission seemed to arise only where

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<sup>281</sup> See [news release](#) on the PMC.

<sup>282</sup> See [planning decision](#).

<sup>283</sup> [HCA response to provisional findings](#), 6.74 Exhibit 4.

<sup>284</sup> [TLC response to annotated issues statement](#), paragraph 4.2.

<sup>285</sup> Since we could not find recent examples of applications for change to C2 use in the SPA, which would permit the provision on inpatient services, we were not clear whether this would present particular difficulties.



competitors to the entrant raised objections on the grounds that sufficient hospital resources were available in the local area concerned. We noted, however, that hospital groups had generally overcome these difficulties, albeit at the cost of varying amounts of time and money.

- 6.106 We concluded that planning regulations constituted a barrier to entry and expansion in central London but not elsewhere.

### *Strategic barriers*

- 6.107 Our guidance identifies three broad categories of barriers to entry: regulatory, natural (or intrinsic) and 'strategic'.<sup>286</sup> Evidence submitted by parties and the results of our case studies suggested two potential barriers to entry and expansion which could be characterized as strategic:<sup>287</sup>

- (a) PMI recognition: whereby a PMI declines to recognize new healthcare facilities; and
- (b) clinician incentives: arrangements between private healthcare providers and clinicians, usually consultants, which may deter or prevent them from working with the entrant.

### *PMI recognition*

- 6.108 Selective recognition of hospital facilities provides a means by which PMIs can negotiate lower hospital prices with hospital operators, exchanging patient volumes<sup>288</sup> for bigger discounts. Through selective recognition the PMI can channel its customers to the facility of the hospital operator that has offered the most favourable terms in a particular geographic area. These terms may extend to exclusivity arrangements in that the PMI, in exchange for an agreed discount, will use a particular hospital as its exclusive supplier in an area. Such exclusivity arrangements would have the effect of denying the operator thus excluded from access to the PMI's customers. For a new entrant, lack of, or the prospect of failing to secure, PMI recognition could thus constitute a barrier to entry.
- 6.109 By the same token, exclusivity deals/refusal of recognition deny the PMI's customers access to the excluded hospital, thus offering them less hospital choice locally than would another PMI which did not operate a selective recognition policy. In deciding whether or not to recognize a hospital, a PMI will need to consider the number of customers it has in the area concerned and the probability that they may defect to another PMI if, say, the excluded hospital is more attractive than the one it recognizes. PMIs are not, therefore, motivated exclusively by the price they can extract from a hospital operator. They also have to bear in mind the perceived quality of hospital operators and the number of their customers, both individual and corporate, in the area concerned.
- 6.110 AXA PPP, the UK's second largest PMI, has chosen to recognize healthcare facilities on a selective basis in its acute inpatient and day-case network, in effect inviting tenders for recognition on that network. A rival to the successful provider which is denied recognition will therefore not have access to patients funded by AXA PPP who hold a network policy (unless that patient is granted a medical exemption) but

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<sup>286</sup> CC3, paragraphs 217–221.

<sup>287</sup> Our guidelines identify three entry barriers: natural, regulatory and strategic.

<sup>288</sup> Because of their high fixed costs, the profitability of private hospitals is very sensitive to volume.

will nevertheless have access to AXA PPP patients requiring outpatient diagnostics and treatment. Further, some agreements between AXA PPP and hospital operators contain an obligation on the parties to review prices if volumes vary beyond certain specified limits as a result of AXA PPP's decision to recognize another provider.

- 6.111 In our case study on Bath, we found that AXA PPP had delayed recognizing Circle and that it had done so because of its broader commercial relationship with BMI which it did not wish to jeopardize. In particular, AXA PPP took into account the potential effects of its decision on Circle Bath on its new, and commercially significant, Corporate Pathways product.
- 6.112 Circle said that there were two issues in respect of PMI recognition which needed to be separately considered: the market power of the major hospital operators on the one hand; and the market power of PMIs on the other. It said that whilst PMI recognition may be withheld from a potential new entrant as a result of the wielding of market power by one or more major hospital operators, recognition could also be withheld by virtue of the market power of the PMI itself and that a PMI may have a number of reasons to refuse recognition. It told us that Bupa, for example, had indicated that it would only grant recognition to Circle's new Reading facility if Circle agreed to pay any shortfall between the Bupa rates and the fees that the consultants wished to charge.<sup>289</sup>
- 6.113 Spire made a similar observation. It said that it was unclear why non-recognition would be a concern with respect to entry barriers if it were influenced by another player in the market, but not if it were implemented independently by a PMI.<sup>290</sup> It said that recognition by the key insurers was fundamental to the viability of any given facility and referred to previously submitted evidence that the initial lack of recognition of its Montefiore Hospital in Brighton by AXA PPP, [X], especially when the delay in obtaining recognition meant that the two largest PMIs were not allowing their insured patients to use the hospital for a considerable period of time.<sup>291</sup>
- 6.114 HCA argued that the only barrier to entry in central London was PMI recognition, as was illustrated by the examples of its Brentwood and New Malden medical centres.<sup>292</sup> It said that there was no evidence that large hospital groups were able to induce PMIs to deny recognition to other private hospitals.<sup>293</sup> However, it said that PMIs had an incentive not to recognize a new hospital offering complex treatments as this would reduce the PMI's expected claims costs.<sup>294</sup> HCA told us<sup>295</sup> that when deciding whether to recognize a new facility or treatment, a PMI would weigh the costs and benefits of recognition. The costs include the expected payments it would be required to make to innovating hospital operators for treating patients at the new facility and/or with the new treatment. These investments/innovations by a hospital operator may increase the range of treatments available to PMI patients, for example where previously the conditions were untreatable or could be treated only at the NHS. The PMIs themselves have referred to 'supplier induced demand'. HCA told us that the adverse cost effect of recognizing new treatments or services (ie the effect of driving up claims costs) may create a disincentive to recognition. HCA also told us that it had provided us with a number of examples where PMIs, through leveraging their buyer power, had stifled investments in facilities and treatments.

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<sup>289</sup> [Circle response to provisional findings](#), p2.

<sup>290</sup> [Spire response to provisional findings](#), 6.2.

<sup>291</sup> *ibid*, 6.6.

<sup>292</sup> [HCA response to provisional findings](#), section 6, summary.

<sup>293</sup> *ibid*, 6.2.

<sup>294</sup> [Submission supplementing HCA's remedies hearing](#), paragraph 6.1.

<sup>295</sup> *ibid*, paragraph 1.9.

- 6.115 Nuffield was of the view that PMI recognition did not, in itself, constitute a barrier to entry but argued that this did not preclude the possibility that certain network configurations could deter entry.<sup>296</sup> It said that, outside of central London, some private hospital groups might be in a position to charge PMIs what it described as 'heavily inflated' prices unless they agreed to contract for high patient volumes. It said that these groups were able to do so because of the number of 'must-have' hospitals that they owned. Nuffield said that as the PMIs could face 'punitive price increases' if they failed to meet the contracted patient volumes, they had no incentive to consult with the wider market on the inclusion of excluded hospitals or new entrants.
- 6.116 Aspen told us that it had encountered barriers to entry in the London market only. It said that it experienced problems securing recognition from AXA PPP both for its Holly House and Highgate facilities. Aspen told us that it took it several years to achieve recognition from AXA PPP due to what it claimed were ongoing threats from the larger providers in the north London market. Eventually recognition was granted but in order to gain that recognition Aspen had to agree to grant significant discounts compared with its existing facilities in London.

### *Conclusions on PMI recognition*

- 6.117 Clearly, because of their size, and also the effect of 'consultant drag', if one or both of the largest PMIs were to decline to recognize a potential new entrant it would make it difficult for it to enter a local market successfully. In assessing whether PMI recognition constitutes a barrier to entry, however, we need to consider the likelihood of a PMI declining to recognize an entrant (ie its incentives) and, if it did decline to do so, whether there were strategies available to the entrant that could nonetheless render it viable.
- 6.118 Whether a PMI has an incentive not to recognize a new entrant appears to vary with the particular local competitive circumstances and how important the PMI considers the operator to be on a national scale.
- 6.119 In Bath, for example, AXA PPP did not have a national relationship with Circle to consider. As a result, the number of subscribers or large corporates it had in Bath who would switch to another PMI, because they could not use the Circle hospital, was unlikely to be significant. Here, on balance, it appeared that AXA PPP's incentives favoured delaying Circle's recognition.
- 6.120 On the other hand, we saw in our London case study how AXA PPP recognized the new TLC facility even though it had an important 'national' relationship with HCA for whom the issue was important: HCA had invested heavily in radiotherapy equipment and feared a reduction in its usage if TLC's Cancer Centre was recognized. Here, AXA PPP's incentives appear to have favoured recognition. We noted that AXA PPP's recognition of the new TLC facility tended to contradict HCA's argument that PMIs had an incentive not to recognize new hospitals offering complex treatments. The delays and difficulties in recognition of its own facilities which HCA cited, however, included outpatient and diagnostic centres which do not provide complex treatments [§].
- 6.121 However, even where PMI recognition has been denied, this does not appear to have forestalled entry. In Bath, Circle adopted measures to mitigate lack of PMI recognition, including meeting the treatment of AXA PPP subscribers itself, albeit at high

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<sup>296</sup> [Nuffield response to provisional findings](#), p3.

cost, and seeking to grow its NHS revenue. Aspen told us that it focused on its existing core, cosmetic surgery, business while trying to negotiate recognition rights with AXA PPP. In other cases hospital operators have agreed to further requests for discounts in order to secure recognition.

- 6.122 In most of the examples we found of PMIs withholding, or threatening to withhold, hospital recognition, the eventual outcome was that the hospital operator(s) agreed additional discounts with the PMI in exchange for recognition. [X] Nonetheless, even if entry was not thus forestalled, it was made more difficult or expensive or protracted as a result of delays in agreeing recognition terms. We concluded, on balance, that PMI recognition did not constitute a barrier to entry.

*Schemes that may encourage or oblige clinicians to use hospital operators' facilities*

- 6.123 We have analysed schemes used by hospital operators to encourage or oblige clinicians, and in particular consultants, to use their facilities in two contexts. First, we considered whether such benefits and schemes could act as a barrier to entry. Secondly, we considered whether they may distort competition between hospital operators. Below we consider the first question: whether such schemes operate as a barrier to entry. We consider whether they may distort competition between hospitals in Section 8 of this report, where we also set out the various schemes which hospital operators have put in place to attract and retain consultants.
- 6.124 While we found that there was no shortage of consultants, in aggregate, from our case studies and other evidence, we found that attracting and retaining consultants to practise at their hospital is a key risk factor for new entrants. If the incumbent hospital operator had adopted an incentive scheme or arrangements which obliged consultants to practise at its hospital, the new entrant might find it difficult to attract patients to its facility. We therefore considered whether such schemes could potentially act as a barrier to new entrants.
- 6.125 We noted that incentive schemes and similar arrangements have the capacity to reinforce incumbency advantages. The incumbent would have the ability to launch a scheme and begin building up clinician entitlements to rewards months, if not years, before the entrant was scheduled to open, as we saw in Bath, or to prepare a scheme for launch should entry occur, as we saw in Edinburgh.
- 6.126 On the other hand, although examples of entry through the creation of a new hospital are rare, in recent episodes that we have examined the new entrant has, in each case, sought binding commitments from consultants to practise at the hospital in exchange for a consideration, usually an equity stake or equivalent interest in the new hospital business. This indicated that new entrants too are able to devise and operate such schemes and that they could be an important factor in facilitating new entry and overcoming any incumbency advantages that the existing hospital enjoyed.
- 6.127 We concluded that incentive schemes and arrangements which created referral obligations could be a means of lowering barriers to entry but, equally, they could be used to strengthen incumbency advantages.
- 6.128 In response to our Remedies Notice, Circle, whilst welcoming the CC's recognition that equity ownership may help reduce barriers to entry, said that the CC's thinking, including on possible remedies arising from its provisional finding, required further development and clarification.

- 6.129 It said that it believed that any attempts to prescribe when equity incentives reduced barriers to entry and when they did not raised numerous practical questions and had enormous consequences for providers and clinician-owned practices.<sup>297</sup>
- 6.130 Ramsay strongly disagreed with the CC's provisional finding as regarded the beneficial effects such schemes may have on barriers to entry. It said, first, that this was tantamount to approving the payment of incentives to interfere with important clinical decisions, which it said was not appropriate on the grounds of encouraging new entry or otherwise. Second, it said that, on any basis, equity schemes (such as the Circle model) were a means of passing a financial advantage to consultants with the direct intention of influencing their clinical decision-making. Thirdly, it said that the proposition that such schemes may confer patient benefits through promoting new entry was plainly and demonstrably wrong. It said that the barrier to entry identified by the CC arises from the cost of funding new facilities in the environment where there is surplus capacity to meet private patient demand.
- 6.131 Ramsay said that the effect of such schemes was demonstrated by Circle's entry into Reading, where Ramsay-insured patient admissions and admitted care revenues at its Berkshire Independent Hospital fell [§]. It said that these decreases were directly related to the loss of a number of key consultants who were 'locked in' with Circle (or incentivized to treat a significant proportion of their patients at the Circle hospital). Ramsay said that it was unaware of any argument to suggest that the payment of incentives created new demand rather than replace open competition for patients with remuneration for referrals.<sup>298</sup>
- 6.132 HCA said that the binary distinction that the CC appeared to draw between 'new hospitals' and equity schemes applying to other facilities such as individual pieces of diagnostic equipment was not meaningful or practicable. It said that the pro-competitive impact of equity schemes which unlocked new investment and encouraged the delivery of new products applied both to new clinical units and facilities owned by an existing hospital operator. It cited two examples of developments which would not have come to fruition without 'consultant engagement': Robotic radiosurgery LLP and the New Malden Diagnostic Centre.
- 6.133 HCA said that the Robotic Radiosurgery JV, which operates the CyberKnife treatment facility at the Harley Street Clinic, involved major investment of [§] and it was integral to the success of the project for the consultants to commit to the development of the unit. It quoted its business case which stated that its strategy (a JV with the clinicians concerned) reduced the projects risk by more closely aligning the physicians' interest with that of the hospital.<sup>299</sup> It set out a similar argument for the New Malden Diagnostic Centre, [§].
- 6.134 HCA concluded that in the case of both of these projects, the consultants' involvement was a key part of the business case and therefore both were examples where equity schemes had pro-competitive benefits in terms of facilitating new investment.<sup>300</sup>
- 6.135 Spire agreed with the CC's provisional finding that equity participation was an effective means of incentivizing consultants to commit to working at a new hospital,

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<sup>297</sup> [Circle response to provisional findings and Remedies Notice](#), p3.

<sup>298</sup> [Ramsay response to Remedies Notice](#), paragraphs 5.12–5.26.

<sup>299</sup> We consider the distortions that may arise by aligning a clinician's interests with those of the hospital rather with those of the patient in Section 8 of our report.

<sup>300</sup> [HCA response to Remedies Notice](#), paragraphs 9.9–9.13.

thereby supporting the entry of new facilities. It gave as an example its Montefiore Hospital which it said had had a positive effect on competition in Brighton.<sup>301</sup>

- 6.136 Bupa said that it did not believe that it was practicable to identify clearly those equity participation schemes that were likely to be as beneficial to competition, as any distortion was harmful. Consequently, it said that an attempt to draw such a line between different schemes would be likely to create inconsistencies and complexity at the expense of clarity.<sup>302</sup>
- 6.137 AXA PPP, in the context of remedies, said that it did not agree with the proposition that certain equity schemes should be permitted as they may lower barriers to entry. It said that it believed that all such schemes should be banned.<sup>303</sup>

### *Conclusion on incentive schemes as a barrier to entry or expansion.*

- 6.138 We found that incentive schemes and arrangements which create consultant referral obligations have the capacity to influence referral conduct. For this reason, if an incumbent hospital operator has such a scheme in place, unless the potential entrant can offer equivalent or better inducements to consultants, the incumbent could, potentially, prevent or deter the rival hospital operator from entering its territory by denying it access to sufficient or appropriate consultants to enable it to offer a broad range of services. Schemes to attract and retain consultants could thus constitute a barrier to entry if incumbents were better able to provide incentives or create referral obligations than could potential entrants.
- 6.139 We found, however, that in all recent episodes of entry or expansion where a hospital operator has created or sought to create a new hospital, consultants had been offered inducements, usually the opportunity of equity participation or its equivalent, in return for a commitment to treat patients at the hospital concerned. We further found that these schemes had been effective in attracting consultants and in persuading financial backers to support the projects concerned.
- 6.140 That said, we acknowledge that there have not been many episodes of entry or expansion available to consider and there might be circumstances where an operator, by virtue of its incumbency, was able to offer a more attractive scheme than the entrant.
- 6.141 We concluded that, nevertheless, and taking all factors into account, including the remedies we are introducing with regard to them (see Section 11 of this report), incentive schemes and arrangements which create consultant referral obligations do not constitute a barrier to entry.

### *Conclusions on barriers to entry and expansion*

- 6.142 We have examined the extent to which incumbent private hospitals are constrained by the threat of entry or expansion. We concluded that barriers to entry and expansion exist and that their significance varies, in particular between central London and elsewhere.
- 6.143 We concluded that in all local areas, including in central London, a combination of high sunk costs and long lead times associated with setting up a private hospital

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<sup>301</sup> Spire response to Remedies Notice, paragraph 6.3(b).

<sup>302</sup> Bupa response to Remedies Notice, paragraph 5.14.

<sup>303</sup> AXA PPP response to Remedies Notice, paragraph 1.23.

together constituted a significant barrier to entry and expansion. We concluded that this was likely to be particularly evident where there was overcapacity in the local area or if demand was small, flat or contracting.

- 6.144 In addition, we concluded that in central London, as well as a combination of high sunk costs and long lead times constituting a barrier to entry and expansion, the lack of availability of suitable sites from which to operate a private hospital and the difficulty in obtaining planning permission for a private hospital also constituted significant barriers to entry and expansion.

#### *Local competitive constraints—introduction*

- 6.145 We have analysed local concentration and its relationship with prices for self-pay patients by carrying out a PCA and this analysis is supported by our review of internal documents provided by hospital operators (see paragraphs 6.256 to 6.275). As noted in paragraphs 6.296 to 6.301, the hospital operators and the PMIs disagreed on whether there were ‘must-have’ hospitals. As a result, in this section, we focus on competition for insured patients, where the strength of local competition will depend on the ability of a PMI to switch its patients away from a hospital given the availability of substitutable rival hospitals. As each PMI needs to be able to offer local hospital cover which meets the needs and expectations of many geographically dispersed policyholders, a hospital will only be effectively constrained where there are alternative hospitals that are suitable not just for some, but for a substantial number of policyholders in the area.
- 6.146 In this section, we first describe our initial filtering exercise which led us to identify a first set of hospitals that we refer to as the ‘hospitals of potential concern’. We then present the methodology used for our local assessments of hospitals located outside central London and the conclusions on the number of hospitals we consider to be insufficiently constrained. Finally, we present our competitive assessment in relation to hospitals located in central London.

#### *Initial filtering*

- 6.147 The aim of our initial filtering exercise was to identify and exclude from further analysis those hospitals where we could, by a systematic method, form a view that they were unlikely to raise competition problems. The remaining hospitals were identified as ‘hospitals of potential concern’ and evaluated in more detail. Our approach to filtering has been conservative, ie more likely to filter in a hospital where there is no problem than filter out a hospital where there is a problem (for example, in relation to the catchment area delineation and the selection of the thresholds for our filters). We considered this to be appropriate because it decreases the risk of overlooking hospitals that may be a concern.
- 6.148 For the purpose of our initial filtering, we adopted two approaches, which we used together, to measure the concentration of hospitals at the local level: one concentration measure was based on fascia counts within a pre-specified catchment area and another measure was based on weighted average market shares, which we referred to as LOCI. Our general approach to filtering and the main results are set out below. Full details of the LOCI measure, including comments received from the parties and our responses, are set out in Appendix 6.4. A full description of our approach and results, as well as the comments raised by the parties and our responses, are presented in Appendix 6.5.



- 6.149 As described in paragraph 5.52(c), our competitive assessment has focused on: (a) the 215 general private hospitals and general PPUs providing inpatient care and active in one or more of the 16 specialties; and (b) the 135 general private hospitals and PPUs (out of 215 in total) plus four specialized private hospitals and PPUs providing inpatient care and offering oncology. The list of these hospitals is provided in Appendix 6.6.
- 6.150 In relation to these hospitals, we have used catchment areas, the areas where most insured hospital patients live, for two purposes. First, as discussed in paragraphs 5.55 to 5.69, they were used to inform our understanding of the local geographic market for each hospital located outside central London. We take a hospital's catchment area to be indicative of the relevant geographic market for that hospital but we also consider competitive constraints from outside the market. Second, we have used the catchment areas to calculate fascia counts.
- 6.151 We defined a hospital's catchment area as the radius within which a given percentage of the hospital's patients originate from. We have used 80 per cent<sup>304</sup> as the proportion of patients, and have measured the radius based on road distances (in miles) between patient home postcodes and hospital postcodes.<sup>305</sup> We have used insured patients data for inpatient treatments within the 16 specialties and oncology together over the period 2009 to 2012 (part year) to derive individual hospital catchment areas.<sup>306</sup> We found that most hospitals have a catchment area with a radius of between 10 and 25 miles, although we observed significant variation in these catchment areas.
- 6.152 Having delineated the hospital catchment areas, we have defined the fascia count concentration measure as the total number of competitors that lie within a hospital's catchment area; a competitor is defined as one or more private hospitals/PPUs that are owned or managed by the same rival operator (eg if a hospital has a fascia count of 1, it has one rival operator, owning one or more hospitals, in its catchment area).
- 6.153 We have used two fascia count measures: (a) a fascia count that includes as competitors all general private hospitals and general PPUs providing inpatient care and offering one or more of our set of 16 specialties (215 general private hospitals and general PPUs in total); and (b) a fascia count that includes as competitors only those general and specialized private hospitals and PPUs providing inpatient care and also offering oncology services (139 oncology providers in total, comprised of general private hospitals, general PPUs and specialized private hospitals and PPUs).
- 6.154 The second concentration measure that we have used is the LOCI measure. The LOCI measure we have used is defined as 'one minus a hospital's weighted-average market share' and is therefore a market-share-based concentration measure. Market shares are adjusted to take into account the common ownership of other hospitals located in any area where the hospital draws its patients from.<sup>307</sup> The weighting scheme assigns more weight to those areas where a hospital draws a large proportion of its total patients—in practice, this typically means more weight is given to those areas nearby to a hospital. LOCI always lies between zero and one; zero can be thought of, in theory, as a monopoly benchmark and one as a perfectly competitive benchmark. A higher LOCI corresponds to a lower weighted average market

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<sup>304</sup> The CC and the OFT have used catchment areas based on an 80 per cent distribution in a number of their inquiries. See CC/OFT 'Commentary on retail mergers', March 2011.

<sup>305</sup> In response to our working paper 'Local competition assessment of hospitals of potential concern', Spire queried why we had not used journey times as used in previous CC inquiries. Our reason for using miles is given in Appendix 6.5.

<sup>306</sup> Hospital-specific catchment areas have been calculated for 173 hospitals which are included in the Healthcode data. For the remaining hospitals not included in the Healthcode data we have made assumptions to identify an indicative catchment area.

<sup>307</sup> In Appendix 6.4 we refer to this LOCI measure as 'network LOCI'.



share, and therefore a 'low LOCI' hospital faces a higher degree of local concentration than a 'high LOCI' hospital.

- 6.155 To calculate the LOCI measures for the purpose of the filtering exercise, we have used the same data on insured patient visits as for catchment areas.<sup>308</sup> We have computed two LOCI measures: one based on patient visits (ie volume shares) and one based on revenue shares.
- 6.156 We consider the LOCI measure to have several benefits in the context of this investigation, in particular if compared with the fascia count measure. As described in more detail in Appendix 6.4, where we also address the comments received from the parties, the LOCI measure takes into account the competitive strength of each fascia, the geographic differentiation between hospitals, accurately reflects where the patient demand originates from, and does not rely on a fixed catchment area or other geographic market definition.
- 6.157 We have identified a hospital as being of potential concern if either of the following conditions are met:
- (a) LOCI (patient share) and/or LOCI (revenue share) is below 0.6; or
  - (b) fascia count (set of 16 specialties) and/or fascia count (oncology) is equal to or below 1, ie there is one or zero competitors within the hospital's catchment area.
- 6.158 The role of the filters and related thresholds is to determine which hospitals we evaluate in more detail. Each hospital's fascia count and LOCI measures also provide some background data for the assessment of local competitive constraints for individual hospitals but, as we explain later in this section, do not determine the outcome of our competitive assessment in any mechanistic way. As noted earlier, we consider it important that this initial filtering exercise is conservative so that we do not overlook any hospitals that may be a potential concern. We took this into account when selecting the above thresholds. To determine the LOCI threshold, we considered the market share thresholds that have often been used by the OFT, the CC and the EU to exclude cause of concern, namely less than 40 per cent in undifferentiated product markets.<sup>309</sup> This level corresponds to a LOCI of 0.6. We selected the fascia count threshold (one or zero competitors within the hospital's catchment area) on a similar basis: a fascia count of one corresponds to a local area with two competitors, which if evenly sized would imply market shares of 50 per cent.
- 6.159 On the basis of the filters described above, we found 145 hospitals of potential concern. Our LOCI approach identified 121 hospitals of potential concern (117 based on patient shares and a further four based on revenue share) and our fascia count approach identified an additional 24 hospitals of potential concern (19 based on our 16 specialties and a further five based on oncology). Of the 145 hospitals of potential concern, five were located in central London and these and other private hospitals in central London are considered in paragraphs 6.200 to 6.255.<sup>310</sup> Additionally, while reviewing the 140 hospitals of potential concern outside of central London prior to the provisional findings, we identified four more hospitals that we considered could also face limited competition, we added these to our list of hospitals of potential concern.

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<sup>308</sup> This means we were able to calculate LOCI for 173 hospitals.

<sup>309</sup> CC2, [paragraph 5.3.5](#). European Commission, 'Guidelines on the assessment of horizontal mergers under the Council Regulation on the control of concentrations between undertakings', 2004/C 31/03.

<sup>310</sup> Of the five central London hospitals that were found to be of potential concern, one was captured by the LOCI (patient share) measure and four by LOCI (revenue share).

6.160 In the provisional findings, we assessed the degree of competition at each of the hospitals of potential concern and provisionally concluded that 101 of those located outside of central London were insufficiently constrained. The methodology we applied was set out in the provisional findings. As we said we would do in the provisional findings, we have continued to develop our methodology, incorporating a richer analysis of the data on patient locations and considering arguments raised by the parties in response to the provisional findings. Set out below is the methodology used for our local assessments and our conclusion on the number of hospitals we consider to be insufficiently constrained. The local assessment for each hospital is set out in Appendix 6.7 and a table of each hospital's characteristics used in our local assessment at Appendix 6.8.

*Competitive assessment of hospitals of potential concern (excluding central London)*

6.161 In this section, we present the approach and the results of the local assessments of the hospitals located outside central London which we provisionally concluded were insufficiently constrained. Paragraphs 6.163 and 6.164 set out an overview of our approach; paragraphs 6.165 to 6.174 explain the type of evidence we drew upon in each local assessment, and paragraphs 6.175 to 6.198 set out the approach we adopted in conducting the local assessments.

6.162 We have considered the views expressed by the hospital operators and the PMIs in response to our initial competitive assessments working paper and the provisional findings. These parties made a number of general comments in relation to our methodology and specific comments on the individual assessments. The former are addressed in the explanation of our approach below while the latter are addressed in our individual hospital competitive assessments contained in Appendix 6.7.

- *Overview of our approach*

6.163 The purpose of our local assessments is to investigate whether the competitive constraints currently exerted on each hospital of potential concern for insured patients are sufficient. Paragraphs 6.276 to 6.332 explain how the degree of local competition at these hospitals affects the outcome of national negotiations between hospital operators and insurers.

6.164 The strength of local competition will depend on the ability of an insurer to switch its patients away from a hospital given the availability of rival hospitals. As each insurer needs to be able to offer local hospital cover which meets the needs and expectations of many geographically dispersed policyholders, a hospital will only be effectively constrained where there are suitable alternative hospitals, not just for some, but for a substantial number of policyholders in the area. A threat by an insurer to switch away from a particular hospital is unlikely to be credible if there are a substantial number of policyholders for whom the alternatives would not be attractive—taking into account, for example, location and the range of services provided. Where our local assessment identified that a hospital had a significant number of insured patients for whom the available alternatives would not be attractive, we concluded that the hospital was insufficiently constrained.

*Types of evidence considered*

6.165 In the local competitive assessments the available evidence considered included:

- (a) the location of hospitals and the relative accessibility of rival hospitals (ie the degree of geographic differentiation);

- (b) the hospital's product offer and how this compared to nearby private hospitals and PPUs (ie the degree of product differentiation);
  - (c) the importance of the areas where the hospital is located to PMIs;
  - (d) documentary evidence from insurers and hospital operators;
  - (e) the views of both hospitals and insurers; and
  - (f) evidence of hospitals competing for PMI business at the local level.
- 6.166 As regards the characteristics of the local area and the relative accessibility of rival hospitals we considered:
- (a) the location and distance between hospitals and their proximity to urban centres;
  - (b) where patients attending each hospitals were located and the extent to which rival hospitals also attracted patients from these areas; and
  - (c) transport links, road networks, and travel times to rival hospitals for patients attending the focal hospital.
- 6.167 As anticipated in the provisional findings, we have developed our approach to assessing (b) above. Since the provisional findings, we have created colour-coded maps showing the location and number of insured inpatients attending each hospital, which we refer to as 'heat maps'.<sup>311</sup> These allow us to compare the postcode areas where each hospital drew the most patients and the extent to which the location of its patients overlapped with those attending other hospitals. The maps for each hospital are set out in each assessment in Appendix 6.7.
- 6.168 The maps of patient locations were generated using Healthcode data on insured inpatients attending the hospital between 2009 and mid-2012.<sup>312</sup> As we did not have patient level data on all hospitals and PPUs, it was not possible to generate patient maps in all cases. In order to focus on the more important postcode areas, we excluded from the maps postcode areas where each hospital drew less than ten patients. In most cases the postcode areas mapped captured the vast majority of insured inpatients attending the hospitals. In a small number of cases, it did not, ie our approach excluded a material number of patients. The implications of this are discussed in the relevant local assessments.
- 6.169 In assessing the importance of an area to PMI providers, we considered total PMI patients treated as a proxy for the number of PMI policyholders in an area (see paragraph 6.185).
- 6.170 As regards each hospital's product offer, we considered:
- (a) the range of specialties offered—we looked at how many of the 16 specialties were offered and separately whether oncology was offered;
  - (b) availability and type of ICU—we looked at whether ICU was present and if so, whether critical care level (CCL) 2 or CCL3 was offered; and

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<sup>311</sup> In the provisional findings we used population data as a proxy for the location of patients.

<sup>312</sup> For a small number of hospitals (2 per cent), we were unable to adequately reconcile the Healthcode data with that provided to us by the parties. As such, in these cases the Healthcode data may understate the number of patients attending the hospital. The implications of these differences are discussed in the relevant local assessment. Also in a small number of cases (6 per cent) we do not have data from Healthcode for the full period, the implications are discussed in the relevant assessments.

(c) hospital size by total private admissions (ie excluding NHS) as a measure of presence in the local market for private patients (see paragraph 6.186).

- 6.171 We explain from paragraph 6.175 below how we incorporated the evidence in relation to these factors into our analysis of whether a particular hospital provides a competitive constraint on another hospital.
- 6.172 In relation to documentary evidence submitted by the parties, we have considered internal documents provided by the hospital operators and by the PMIs. Internal documents have been used to assess whether these parties consider, in their normal course of business, private hospitals and PPUs to represent a competitive constraint on each other in local areas (and the extent of any such constraint) and whether these internal documents support the views expressed by the parties. While relevant to our assessment, the fact that a hospital may consider in its internal documents competition from a rival hospital for some of its patients does not in itself mean that an insurer will be able to switch away from the hospital. As such, when reviewing the documents we are interested in the extent to which an insurer can switch to another hospital. Furthermore, in many cases where we have identified hospital operators evaluating competition from rival hospitals, it is often not clear which type of patient (eg insured, self-pay or NHS), which type of treatment or the number of patients they considered are at risk. This clearly has an impact on the weight we can place on some of this evidence. We have considered all internal documents provided by all operators and all PMIs in response to our questions on local competition in the Market Questionnaire, as well as a number of internal documents provided in the course of this investigation, including in response to the provisional findings, which were highlighted for our attention or we found to be relevant to the assessment of local competition.
- 6.173 As regards the views of the parties, we have considered the views expressed by the all hospital operators and all PMIs (in their various early submissions and in response to our working paper, initial assessments<sup>313</sup> and the provisional findings). Although we have taken into account views expressed by PMIs as regards whether a particular hospital was ‘must have’ from their perspective, we note that in a number of cases there is no consensus of opinion. We do not consider this particularly surprising given that there is no clear definition of a ‘must-have’ hospital and their views will reflect individual strategic considerations such as the number and location of their policy-holders (particularly corporate customers), target markets and possibly also previous interactions with different hospital operators at the national level.
- 6.174 Where there is evidence of hospitals competing at the local level in their interactions with insurers, we have evaluated the evidence and where relevant taken this into account. For example, we are aware of instances where insurers have been provided with hospital-specific discounts, where tenders have been organized and where contractual disputes have led to delisting of specific hospitals. In Appendix 6.11, paragraphs 83 to 112, we set out our views on the implication of the high-profile negotiation between Bupa and BMI which led to the delisting of 37 BMI hospitals for a short period in January 2012. Those paragraphs explain that we do not consider that all of the hospitals that were delisted are sufficiently constrained. However, we have taken into account the parties’ internal deliberations as they prepared for these negotiations in which they considered the strength of competition in different areas (see paragraphs 6.290 to 6.332).

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<sup>313</sup> We sent our initial local competitive assessments of the hospitals of potential concern to relevant hospital operators and to Bupa and AXA PPP in May 2013.

### *Interpreting the evidence*

- 6.175 In order to determine that a particular hospital was sufficiently constrained, we would expect to observe that it would be plausible for an insurer to switch away from the hospital given the availability of rival hospitals. As such, our analysis is focused on identifying the number and location of insured patients attending the hospital for whom alternatives would not be attractive. In making this assessment, we considered all the different types of evidence listed above in combination to reach a conclusion on whether each hospital was sufficiently constrained. In particular, we note that when hospitals are similar, ie they have a similar product offering, they are located close to each other and draw patients from similar areas, they are likely to impose a strong competitive constraint on each other. It is not the case that a rival hospital needs to be identical to be an effective competitor, but the more different it is the less likely it will be an attractive substitute. In paragraphs 6.176 to 6.198 we describe in more detail the approach we adopted in making this assessment.

### *Assessing geographic factors*

- 6.176 The analysis of the hospital location, relative to the location of its patients, is central in understanding patients' (and ultimately insurers') willingness to consider different hospitals in their choice set.<sup>314</sup> As explained in paragraph 6.167, we have looked at the number and location of patients attending each hospital on a postcode area by postcode area basis using heat maps. When comparing the location of each hospital's patients, we identified their centres of patient activity, ie the postcodes where most of their patients lived. We then considered the extent to which these postcodes overlapped with those where other hospitals were drawing patients. We typically considered those overlaps where we observed more than 50 patients from a postcode area attending each hospital to be significant, and the greater the number of overlapping patients in each postcode the more weight we attached to the overlap.
- 6.177 In most cases we would expect the overlap between competing hospitals to be large, and the distances that patients would have to travel to be similar, for us to conclude that a rival hospital was an effective competitor. However, it was not necessary for a rival hospital to compete for all patients for it to provide a relevant constraint. We are concerned with the totality of the constraints faced by a hospital and in some cases we found that a hospital faced several competitors, each competing for patients in different locations. As long as there was not a significant group of patients that appeared to have little choice other than the focal hospital, we concluded that the hospital was sufficiently constrained.
- 6.178 Although the heat maps provide a valuable insight into the location of insured inpatients attending each hospital, care needs to be taken when interpreting this evidence. We recognize that there may be examples where a lack of overlap may be misleading. For example, we have observed some hospitals that have very similar characteristics, are relatively close to each other but where each hospital attracts distinct groups of patients from different locations. In some of these cases, given the relative ease of travel between the hospitals, we believe that the pattern of patient activity we observe may tell us more about the convenience of one hospital to patients or GP referral habits (for example, where GPs refer private patients to consultants in a way that closely mimics their NHS referrals) than an unwillingness of patients to travel to the nearby rival. In other cases, evidence of an overlap may exaggerate the degree of competition. For example, where there are significant differences between two hospitals in the range of treatments offered, we would

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<sup>314</sup> This is not to say that other factors, such as range of treatments offered, are not important.

expect to observe more overlap, as some patients may have no choice but to travel further. In other cases, the maps may highlight preferences unrelated to competition, such as strong local connections (eg family and friends) or familiarity with a hospital. As such, all the evidence needs to be seen in the round and our conclusions are based on the full range of evidence available, including road and transport connections, a hospital's product offering, views of the parties and internal documents.

- 6.179 In the provisional findings, we stated, in general, that where we observed two hospitals imposing a similar competitive constraint on each other we would regard these hospitals to be insufficiently constrained, as they would not be expected to compete effectively against each other. However, we recognized that there may be circumstances where two similar operators may provide adequate constraints, eg high fixed costs and spare capacity may provide an incentive to price so as to increase volume. Taking into account comments received by parties and primarily evidence of competition between local hospitals which have been highlighted to us, we now consider that in certain circumstances two hospitals do provide insurers with sufficient alternatives, such that the hospitals are sufficiently constrained. These hospitals would need to have very similar characteristics, they would need to be located close to each other and they would need sufficient excess capacity to enable insurers to switch their business. In this regard, we note AXA PPP's statement: 'To the extent that there are two major hospitals in a moderately sized city, in a broadly symmetric duopoly, it will not always necessarily be the case that the PMI provider has to "stock" both hospitals. As such, the hospitals may (if offered individually) compete to be listed.' This also appears to be borne out by recent evidence, for example we have observed AXA PPP organizing a tender in Leeds between Nuffield and Spire.
- 6.180 However, we also consider that in some cases where we observe a hospital that serves a sizeable urban conurbation, expectations of policyholders with ties to their local area may make it difficult for an insurer to remove access. Again we find a comment from AXA PPP on this point relevant: 'to the extent that two hospitals in adjacent but separate cities compete with each other at a self-pay level, for example because people living between the two cities could "drive either way", in the PMI context the insurer may still need to list one or both'.
- 6.181 There are some hospitals located in the centre of large urban areas which are both large and attract patients from across its region. This may be because for patients located outside these main urban centres, hospitals in the centre of the urban area may be a convenient alternative to hospitals outside the centre due to the transportation links and established travel patterns connecting the outskirts with the centre. These factors may mean that given demands of policyholders for access to certain large urban hospitals, there may be few viable alternatives from an insurer's perspective. In this regard, we note AXA PPP's comment: 'the principal private hospital in a city that is in the commuter belt of any major centre of employment would typically have to be included in the network even if there are a number of private hospitals in a radius around the city that might constrain it in the self-pay market'. Where we have identified a hospital that appears to exhibit these characteristics, we have considered the degree of substitutability with other hospitals on a case-by-case basis, taking into account all available evidence.
- 6.182 Reflecting good transport links and established travel patterns into central London, hospitals in Greater London (outside central London) and in the surrounding commuter areas are likely to face competition for patients from hospitals in central London, particularly for non-routine, high-acuity treatments. This is evidenced by the larger catchment areas we observe for central London hospitals. However, evidence that patients are attracted into central London from the outskirts does not necessarily

mean that central London hospitals are good substitutes to outer London hospitals from the perspective of the insurer. We consider that the higher cost of central London hospitals limits the extent of the constraint they provide on outer London hospitals. For example, [X]. Consistent with this we have observed hospital operators with facilities in commuter areas working with insurers to encourage patients who live in the outskirts not to travel into central London for treatment, for example making arrangements for consultations with consultants based at hospitals in Greater London to take place in central London so that the subsequent treatment will be carried out in Greater London. For this reason, in the local assessments we typically do not consider the constraint provided by central London hospitals on outer London hospitals to be effective.

- 6.183 The common ownership of several hospitals by the same operator in nearby local areas can weaken the competitive constraint provided by a rival hospital. Where a hospital operator owns both the focal hospital and another hospital near to a close rival, were it to face a delisting at the focal hospital it may expect to recoup some of the patients diverted from the delisted hospital through its other facility nearby. For each hospital of potential concern, in assessing whether common ownership was a concern, we have taken into account the ownership and location of other nearby private hospitals or PUs (which themselves may or may not be sufficiently constrained).
- 6.184 We discuss barriers to entry and expansion in paragraphs 6.8 to 6.144. In our local assessments we have taken account of entry where we have supporting evidence, for example KIMS in Maidstone and Spire Montefiore in Brighton.
- 6.185 As well as assessing the alternative hospitals available in a particular area, we have also sought to take into account the significance of the area to the PMI provider. In this regard, several parties noted that areas with high levels of corporate PMI activity were particularly significant, as the harm to a PMI's business will be more pronounced if they failed to offer adequate provision in these strategically important areas. Likewise we would expect that in areas of relatively low PMI penetration the harm to the PMI's business of not being able to offer comprehensive coverage would be less pronounced. In practice, we do not have the data to isolate areas on the basis of PMI penetration or corporate PMI penetration. However, to gauge the general importance of the area for PMI providers, we have compared the total number of PMI patients treated in each UK postcode area as a proxy for the number of PMI policyholders in the area.

#### *Assessing differences in hospital product offerings*

- 6.186 In the provisional findings we noted that size was a relevant characteristic when comparing hospitals, for example we commented that a larger hospital can be a strong constraint on a smaller hospital when these hospitals are not geographically close together but there is a large overlap in their catchment areas. Compared with the provisional findings, we have placed less weight on the relative size of two hospitals in our assessments as we consider that, to the extent it affects the competitive dynamics, it should be captured in our patient mapping exercise. However, as discussed in paragraph 6.181, we note that it is possible to distinguish a few very large hospitals with a strong regional presence. Where evidence is available we consider the implication of this in those assessments.
- 6.187 We continue to compare the relative size of different hospitals in our assessments as we consider it a useful proxy for the capacity of the rival hospital to accommodate additional patients, although we note that it is only a strong indicator in extreme cases—eg a much smaller hospital is unlikely to be a viable alternative to a large

hospital, whereas the very large hospital is likely to be a viable alternative for the smaller hospital. In general, our approach to capacity constraints is that unless we have specific evidence that a rival is capacity constrained, if we see evidence to suggest it is a close competitor, we assume it has capacity to support a delisting by an insurer of the focal hospital. This is consistent with what the hospital operators have told us and data we have seen on excess capacity (see Appendix 6.13, paragraph 128), though it can be difficult to measure excess capacity reliably.

- 6.188 BMI argued that profitability was highly sensitive to volume in a high fixed cost environment and that its hospitals suffered from relatively low levels of capacity utilization so that it had a powerful incentive to price so as to increase volume. We would expect excess capacity to facilitate switching and increase the intensity of competition between local operators where substitution is possible. However, the presence of excess capacity, at either the focal or rival hospital, does not in itself mean that the hospital will be sufficiently constrained if substitution is not feasible because the nearest rivals are too distant to meet the needs of a significant group of the insurer's policyholders.
- 6.189 When considering the size of different hospitals, we predominantly focused our comparison on the number of private patients at each hospital. This reflects the fact that this captures the relative scale of the hospital in the market we are ultimately interested in. As noted above, our general approach has been to assume that rival hospitals have the capacity to absorb an individual insurer's patients so in most cases the number of private patients accurately captures the hospital's relative importance in the relevant local market. However, we recognize that a number of private hospitals utilize a substantial share of their capacity to treat NHS patients. In cases where the capacity to absorb additional patients is relevant, we have taken into account the fact that the hospital operator may be able switch some of this capacity back to private patients. We also note that the ability to switch quickly and easily may be constrained by commitments to prioritize NHS patients over private patients, the need for some investment to adjust the facilities to the requirements of private patients, and the business strategies decided upon at national level.
- 6.190 In our market definition (paragraphs 5.22 to 5.31 and 5.54(b)), we explain that we considered it appropriate to look at 16 specialties largely together, with the exception of oncology which we considered separately. We note that Bupa argued that our assumption that supply-side substitution was possible across specialties was too strong, and any aggregation of specialties would therefore hide pockets of market power. On the other hand, BMI argued that as supply-side substitution was relatively easy, we should not regard the number of specialties offered by a hospital as in any way capable of restricting competition. We thought it appropriate for us to consider the number of specialties offered at each hospital as, in the context of local competition, a significant difference in the range of specialties offered by two hospitals may affect the immediate prospects for substitution. However, we would only expect this to be material where the difference in the number of specialties offered is large. For example, while we recognize that there are a few highly specialized private hospitals and PPUs that may be particularly strong in their chosen specialty, given the difference in the number of specialties offered we are unlikely to regard them, on their own, as a significant constraint on a private hospital.

#### *Identifying the competitor set*

- 6.191 In the provisional findings we identified the set of competitors for each hospital of potential concern on the basis of private hospitals and PPUs that had catchment areas which overlapped with the hospitals of potential concern, including rival hospitals inside and outside the focal hospital's catchment area. Private hospitals (or



PPUs) under common ownership were not considered to be competitors. Since the provisional findings we have also considered the degree of competition from any other private hospital or PPU identified by the parties in response to the provisional findings, as well as any additional private hospitals or PPUs that we considered could be relevant competitors after reviewing maps showing the location of patients attending each hospital (as described in paragraph 6.167).

- 6.192 As explained in Section 5, our market definition includes both private hospitals and PPUs. We have collected data on 16 PPUs managed by private hospital operators as well as 47 PPUs operated by the 30 largest NHS trusts across the UK. Data permitting, PPUs were analysed in the same way as private hospitals. However, in most cases data restrictions meant that we were not able to map the location of patients attending PPUs as we were with other hospitals.
- 6.193 We note that PPUs usually share clinical facilities, such as theatres, with NHS patients. In some cases this may be an advantage for the PPU, for example the PPU will have access to the trust's ICU facilities. Yet, as we note in Appendix 3.1, a number of NHS Trusts emphasized that where constraints arose, for example in terms of access to theatres, NHS patients would always be prioritized. This prioritization of their core NHS business will affect some PPUs' ability to absorb significant numbers of additional private patients where capacity constraints are present. It may also limit growth opportunities where both the PPU and the main NHS hospital place competing demands on the hospital's financial resources. Appendix 3.1 sets out in more detail the evidence we have received regarding PPUs. We have limited information on the attractiveness of PPUs to patients (and therefore their effectiveness as a substitute from the perspective of a PMI). However, we note that there is evidence from the survey which indicates that most patients have a preference for being treated at a private hospital compared with a PPU.<sup>315</sup>
- 6.194 A number of the PPUs that we have identified, or parties have brought to our attention, are small, often very small, and there is limited information available about their activities. In practice, we expect the largest PPUs and those managed by private operators to be the closest substitutes to private hospitals. This reflects the fact that given their size, (a) they are more likely to have the capacity to absorb an insurer's patients, and, (b) they have demonstrated their ability successfully to promote their PPU and attract private patients. In practice where a PPU is several times smaller than the focal hospital and/or there is very little information publicly available about its private activities, in order to conclude it was an effective competitor, we would need to see convincing evidence from parties' internal documents highlighting the PPU as a competitive threat and suggesting that it is capable of attracting more private patients.
- 6.195 Several hospital operators argued that as the recent Health and Social Care Act 2012 abolished the cap on how much revenue an NHS trust could earn from non-NHS sources, PPUs would be stronger competitors going forward than current patient volumes suggested. Appendix 3.1 assesses this argument in detail. Based on the evidence we received and reviewed, we concluded that the lifting of the cap was unlikely to give rise to such significant expansion that PPUs will operate as a substantially greater competitive constraint on private hospital operators in the near future.

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<sup>315</sup> Question D6 asked if your choice of hospital had not been available where would you have attended? 65 per cent stated that they would have had treatment at a different private hospital. Only 10 per cent said that they would have attended a PPU.

- 6.196 In response to the provisional findings, BMI argued that several of its private hospitals were in fact PPUs, given that they were co-located on the site of an NHS hospital. We note that although the examples cited by BMI do share a site with an NHS hospital, in many cases these are dedicated private facilities with stand-alone theatres housed in a building on which BMI has a decade's long property lease (as opposed to a management contract). In such circumstances, we regard these as separate private hospitals belonging to the private operator rather than a PPU of the relevant NHS hospital.
- 6.197 We do not consider private beds in NHS wards to be an effective competitor to private hospitals.<sup>316</sup> The lack of differentiation from NHS services is unlikely to make this an attractive option for many patients seeking private treatment and therefore not a viable substitute for PMIs.
- 6.198 NHS hospitals (as opposed to PPUs) are not included in our market definition. In order to consider constraints from NHS hospitals (ie constraints from outside the market), we asked hospital operators to provide, for each of their hospitals, evidence supporting their view that any NHS hospital represented a competitor. We found no persuasive evidence to suggest that the NHS was a relevant constraint in the context of the substitutes available to insurers. In particular, we have not received evidence that shows that private hospitals considered the performance of local NHS services to affect their local competitive position with respect to insurers. Several hospital operators argued that the fact that some insurers offered a cash incentive in return for a policyholder being treated on the NHS was evidence that the NHS did provide a material constraint. However, we did not find this argument persuasive; even if some PMI policyholders are choosing to be treated on the NHS, it does not mitigate the fact that a PMI will still need to have adequate private hospital provision in a local area to sell PMI policies in that area. Furthermore, where we have observed such policies, they have been general policies applied to policyholders broadly, and we have seen no evidence that this has been used by PMIs to target patients of a particular hospital operator to facilitate more competition locally.

*Competitive assessment of hospitals of potential concern (excluding central London)—conclusions*

- 6.199 Out of 140 hospitals outside central London that were identified as hospitals of potential concern by the filters, following our local assessments, we have identified 70 hospitals that the evidence indicates are subject to insufficient competitive constraints.<sup>317</sup> Tables 6.1 and 6.2 show the breakdown of individual hospitals and the results of our competitive assessments of hospitals outside central London, by hospital type and hospital operator respectively. Our competitive local assessments and conclusions are set out in Appendix 6.7.<sup>318</sup>

TABLE 6.1 Results of competitive assessments of hospitals outside central London, split by hospital type

<i>Hospital type</i>	<i>Total hospitals</i>	<i>Hospitals of potential concern</i>	<i>Hospitals of concern, ie subject to insufficient competitive constraints</i>
General private hospitals	149	123	65
General PPUs	42	17	5

<sup>316</sup> Although we did not address this question in our survey, our survey shows the extent to which insured patients considered the NHS. 80 per cent of insured patients told us that they did not consider having their treatment done on the NHS. 3 per cent of insured patients told us that would have used the NHS had the hospital they attended not been available.

<sup>317</sup> This compares to 101 hospitals that we identified at the point of provisional findings as being subject to insufficient competitive constraints.

<sup>318</sup> This appendix includes assessments and conclusions for 102 hospitals: the 101 hospitals identified in the provisional findings plus an additional hospital that was identified after the provisional findings.

Specialized oncology hospitals	2	0	0
Total	193	140	70

Source: CC analysis.

TABLE 6.2 Results of competitive assessment of hospitals outside central London, split by operator

<i>Hospital operator</i>	<i>Total hospitals</i>	<i>Hospitals of potential concern</i>	<i>Hospitals of concern, ie subject to insufficient competitive constraints</i>
BMI	56	52	37
HCA	2	0	0
Nuffield	31	24	11
Ramsay	22	19	6
Spire	36	32	12
Other—general private hospitals	14	4	4
Other—general PPUs	31	9	0
Other—specialized oncology hospitals	1	0	0
Total	193	140	70

Source: CC analysis.

## Competitive assessment of hospitals located in central London

### Introduction

6.200 In this section, we discuss our assessment of competitive constraints faced by private hospitals including PPUs located in central London. While our analysis of shares of supply considers all customer segments (eg, self-pay and insured patients), our analysis of closeness of competition between hospitals focuses primarily on competition for insured patients. In this respect, as we noted in our discussion of the methodology for our local assessments (see paragraph 6.164), the strength of local competition will depend on the ability of a PMI to switch its patients away from a hospital given the availability of substitutable rival hospitals. As each PMI needs to be able to offer local hospital cover which meets the needs and expectations of many geographically dispersed policyholders, a hospital will only be effectively constrained where there are alternative hospitals that are suitable not just for some, but for a substantial number of, policyholders in the area. Given product and geographic differentiation, as set out in paragraphs 5.54, 5.60 and 5.61, regardless of the precise boundaries of the central London market, our competitive assessment looks at the strength of the competitive constraints that central London private hospitals and PPUs face from within and outside the market.<sup>319</sup>

6.201 Private provision of healthcare services in central London substantially outweighs any other single region of the UK. In sum, central London accounts for around 30 per cent of all UK private hospital revenue and the proportion is higher for inpatient revenue, at around 37 per cent. Central London also contains a significantly higher number of private hospitals and PPUs than other regions in the UK. In particular, out of the 219 private hospitals and PPUs providing inpatient care we have looked at (see paragraph 5.52(c)(ii) and (iii)), 16 private hospitals and ten PPUs are located in

<sup>319</sup> For the purposes of our analyses, we have used standard definitions of central London and Greater London. Our definitions for central London and Greater London are the NUTS2 regions named 'Inner London' and 'Outer London', respectively. NUTS stands for 'Nomenclature of Territorial Units for Statistics' and is a delineation of geographic areas developed and regulated by the EU. A map of UK NUTS regions can be found at: [www.ons.gov.uk/ons/guide-method/geography/beginner-s-guide/maps/index.html](http://www.ons.gov.uk/ons/guide-method/geography/beginner-s-guide/maps/index.html). In terms of private hospital and PPU locations, our central London definition coincides with the area inside the North and South Circular Roads, and our Greater London definition is similar (but with some exceptions) to the area between the North and South Circular Roads and the M25 ring road. We use the term 'London' to refer to the combined area of central London and Greater London.

central London. These are as follows (see Appendix 6.10, Annex B, for the list of hospitals):

- (a) HCA operates eight hospitals: it owns seven private hospitals<sup>320</sup> and manages one PPU;<sup>321</sup>
- (b) BMI owns and operates four private hospitals;
- (c) Aspen owns and operates one private hospital;
- (d) there are four hospitals owned and operated by independents: the Bupa Cromwell Hospital, the Hospital of St John and St Elizabeth, the King Edward VII's Hospital Sister Agnes, and TLC; and
- (e) there are nine PPUs (excluding the PPU managed by HCA) owned and operated by six NHS trusts.

6.202 We note that, in the OFT reference decision, the OFT stated that PMIs and hospital operators had raised concerns in relation to the London area.<sup>322</sup> We have also received a significant number of complaints from industry participants about the perceived lack of competition between private hospital operators in central London. These complaints have come from PMIs, but also from certain hospital operators. The complaints have typically cited the lack of competition and the strong market position of HCA.

6.203 This section is structured as follows. We first examine competitive constraints within the market (see paragraphs 6.204 to 6.219) at an aggregated level (17 specialties) and a disaggregated level (eg by specialty, for the more complex specialties such as cardiology and oncology). Within the market we looked at: shares of supply, using admissions and revenue; shares of capacity; product range and quality; locations of hospitals; views of the parties; and parties' internal documents. We then examine competitive constraints from outside the market, in particular from the NHS and from Greater London hospitals (see paragraphs 6.220 to 6.228). We also consider HCA's vertical integration in GP practices (see paragraphs 6.229 and 6.230). We then summarize and respond to HCA's views, to the extent that this is not covered in the previous sections (see paragraphs 6.231 to 6.253). Finally, we present our conclusion on the degree of competition in central London (see paragraphs 6.254 and 6.255). Appendix 6.10 sets out in detail the evidence and analysis of the competitive constraints in central London. We have also carried out other pieces of analysis relevant for central London: self-pay prices (see paragraphs 6.256 to 6.275), insured prices (see paragraphs 6.276 to 6.383), quality and range (see paragraphs 6.384 to 6.440) and profitability (see paragraphs 6.441 to 6.447).

### *Competitive constraints between private hospitals including PPUs in central London*

6.204 We first considered the shares of supply of private hospitals including PPUs located in central London. We measured shares of supply by patient admissions (inpatient only and inpatient plus day-patient, which we refer to as total)<sup>323</sup> and revenue (inpatient only and inpatient plus day-patient plus outpatient, which we will refer to as

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<sup>320</sup> We note that there are other HCA facilities in central London that do not provide inpatient services but are operated in conjunction with one of the seven HCA private hospitals in central London. Therefore, we have included these facilities in our shares of supply analysis. For details, see Appendix 6.10, footnote 2.

<sup>321</sup> We note that HCA has won a tender to operate a further PPU in central London at Guy's NHS Trust.

<sup>322</sup> OFT, 'Private Healthcare Market Study', April 2012.

<sup>323</sup> We note that only inpatient and day cases are 'admitted' to a hospital and hence 'total admissions' only refer to these.

total). We conducted our analysis at an aggregated level (all specialties and treatments), and at several disaggregated levels (eg by specialty). Hospitals belonging to a single operator have been considered together.

- 6.205 As set out in Appendix 6.10, paragraphs 36 and 37, our analysis of shares of supply at the aggregated level indicated that central London is a highly concentrated market and that HCA has high shares of supply relative to its competitors. HCA has a share of supply in central London above 45 per cent by admissions (inpatient and total) and above 55 per cent by revenue (inpatient and total). On the basis of total admissions, the hospital operators with the next largest shares are: TLC ([10–20] per cent), BMI ([5–10] per cent) and Bupa Cromwell ([5–10] per cent). Also on this basis: all other private hospital operators individually have shares below 5 per cent; the nine PPUs each individually have shares below 5 per cent; and the nine PPUs collectively have a share of [10–20] per cent. The results are similar for shares on the basis of inpatient admissions, inpatient revenue and total revenue.
- 6.206 Our disaggregated analysis evaluated shares of supply for individual specialties, and also in segments of the central London market that may be indicative of the more complex, specialized or high-acuity work. These segments are: the more complex specialties (ie cardiology and oncology), hospitals that have CCL3 beds (ie that can offer the highest level of intensive care), and tertiary treatments (ie those that require a referral from one consultant to another consultant).<sup>324</sup>
- 6.207 Our disaggregated analysis, set out in Appendix 6.10, paragraphs 40 to 49, showed that HCA has a high share of supply by total admissions in many specialties, and that HCA's share is particularly high when considering the complex segments of the central London market. For providers other than HCA, our disaggregated analysis showed that TLC, for most measures, has shares of supply that are closer to those of HCA than other hospital operators. TLC shares, by most measures, are, however, substantially smaller than HCA's shares and in several cases they are below one-third of HCA's share. Other providers typically have shares of supply even lower than those of TLC, below 10 per cent for most measures.
- 6.208 In particular, our disaggregated analysis showed that:
- (a) HCA has the largest share by total admissions in 12 out of 17 specialties and TLC has the largest share by total admissions in three specialties.<sup>325,326</sup> TLC has the second largest share in four specialties,<sup>327</sup> for three of which HCA has the largest share; BMI has the second largest share in four specialties.<sup>328,329</sup>
  - (b) HCA has a share by total admissions of over 40 per cent in 10 of 17 specialties. TLC and St John & St Elizabeth each have a share of total admissions over 40 per cent in one specialty.<sup>330</sup> No other hospital operator has shares in individual specialties above 40 per cent.

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<sup>324</sup> Our definition of tertiary treatments is based on information provided by Spire, which provided us with a list of tertiary treatments performed at its hospitals. Spire noted that there were a number of different approaches to defining tertiary care and that the provision of this information necessarily involved an element of subjective judgement by the individual hospital directors because there was no universally accepted definition of tertiary care and individual hospital directors might have different views on what amounted to tertiary care at their hospitals.

<sup>325</sup> Ophthalmology, oral and maxillofacial surgery and otolaryngology.

<sup>326</sup> Hospitals of St John & St Elizabeth and Aspen have the largest share in dermatology and plastic surgery, respectively.

<sup>327</sup> Gastroenterology, urology, clinical radiology and dermatology.

<sup>328</sup> Trauma and orthopaedics, general surgery, anaesthetics and otolaryngology.

<sup>329</sup> Providers other than HCA and TLC have shares of supply by total admissions which are below 10 per cent for most individual specialties. BMI is the exception to this and has a share by total admissions above 10 per cent in six of 17 specialties (trauma and orthopaedics, general surgery, urology, anaesthetics, otolaryngology, and rheumatology).

<sup>330</sup> Oral and maxillofacial surgery for TLC and dermatology for St John & St Elizabeth.

- (c) HCA has a share by total admissions of over 55 per cent in each of the four most common specialties ([60–70] per cent in oncology, [60–70] per cent in trauma and orthopaedics, [50–60] per cent in gastroenterology and [60–70] per cent in obstetrics and gynaecology). The corresponding shares are below 10 per cent for all other operators except for TLC in gastroenterology at [60–70] per cent and for BMI in trauma and orthopaedics at [10–20] per cent.
- (d) HCA has a share by total admissions of over 60 per cent in specialties that might be considered more complex (ie oncology and cardiology). The corresponding shares are below 10 per cent for all other operators.
- (e) HCA has a share by total admissions of over 50 per cent when considering only those central London hospitals that have CCL3 beds (ie slightly higher than when considering all central London hospitals). This compares to [10–20] per cent for TLC, [5–10] per cent for Bupa Cromwell and [0–5] per cent for BMI.
- (f) HCA has a share by inpatient admissions of over 60 per cent in tertiary treatments. This compares to [10–20] per cent for TLC, [10–20] per cent for BMI and [5–10] per cent for Bupa Cromwell.

6.209 We have also analysed shares of capacity of central London hospitals. We considered four measures of capacity: number of overnight beds, number of theatres, number of consulting rooms and number of CCL3 beds. In relation to PPUs' capacity which is dedicated to private patients, we have used data from the Laing and Buisson report<sup>331</sup> on the number of NHS dedicated beds for PPUs; however, we were unable to find data for the other three measures of capacity for PPUs.<sup>332</sup> Our analysis of capacity shares using the other three measures is therefore confined to private hospitals.

6.210 The results of our share of capacity analysis, presented in Appendix 6.10, paragraphs 50 to 52, showed that HCA operates [40–50] per cent of private hospitals' and PPUs' overnight bed capacity in central London. The results for the other three measures of capacity, which exclude PPUs, also showed high shares for HCA. HCA's share of private hospital theatres is [40–50] per cent and of consulting rooms is [40–55] per cent. In the case of CCL3 beds, HCA has an even higher share of private hospitals' capacity, at [60–70] per cent. The second largest operator in terms of capacity shares is TLC, which accounts for [10–11] per cent of overnight beds, [10–20] per cent of theatres, [10–20] per cent of consulting rooms, and [10–20] per cent of CCL3 beds. The third and fourth largest providers in terms of capacity shares by all measures are BMI and Bupa Cromwell. In terms of overnight bed capacity, all other private hospital operators individually have shares below 5 per cent; the PPUs individually have shares below 5 per cent, with the exception of Imperial College NHS Trust which has a share of [5–10] per cent; and the PPUs collectively have a share of [10–20] per cent.

6.211 On the basis of our shares of supply analysis described above, we found central London to be a highly concentrated market in which HCA has a strong position across all specialties and an even stronger position when considering the most common specialties and the more complex segments of the market (see paragraph 6.208). TLC is the next largest operator across all specialties and in the more com-

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<sup>331</sup> Laing's Healthcare Market Review 2011/12.

<sup>332</sup> PPUs' responses to our market questionnaire indicated that theatres and critical care level beds in particular are not dedicated to private patients. For example, King's College Hospital NHS Foundation Trust noted that there were 18 theatres and 72 level 3 critical care beds across the trust. Priority was given to NHS patients so that NHS care was not compromised. The PPU access to these facilities was flexed accordingly. Royal Marsden told us that as an NHS provider of private care, not all of its facilities were solely dedicated to private care. This was, in particular, with reference to operating theatres and critical care.

plex segments of the market (in terms of hospitals with CCL3 beds and tertiary treatments), but it is substantially smaller than HCA. Our analysis of hospital operators' shares of capacity also supports this conclusion. We discuss HCA's views in relation to our share of supply and capacity analysis further below.

- 6.212 The differentiated nature of healthcare provision suggests that, in addition to shares of supply and capacity, substitutability should be assessed considering the relevant dimensions of differentiation, including product range and quality, and hospital location. In differentiated markets, the stronger competitive constraints typically arise from competitors closer to each other over the various competitive dimensions, ie range, quality and location. We also considered in detail the strength of competitive constraints from PPUs. We look at these topics in turn.
- 6.213 We discuss product range and quality in paragraphs 6.388 to 6.426. Recognizing that there is a lack of objectively comparable measures of quality, we considered that the evidence available to us did not lead us to conclude that HCA's quality was materially higher than the quality of a number of HCA's central London competitors, including TLC, St John and St Elizabeth and King Edward VII (see paragraph 6.412). Regarding product range, although we found that there is a degree of horizontal differentiation, this does not appear to be perceived by HCA as a significant differentiator between its hospitals and those of some of its competitors, in particular competitors in central London (see paragraph 6.411). In relation to TLC, HCA told us that TLC offered a comprehensive range of treatments (including complex treatments).<sup>333</sup> Whilst we found that HCA does offer a wider range of treatments than TLC, we also considered that the difference in product range between HCA and TLC is likely to be explained to some extent by the difference in the sizes of their hospital portfolios and that both HCA and TLC have expanded their range in recent years (see paragraphs 6.414 to 6.416).
- 6.214 With regard to location, we note that HCA hospitals are all located inside central London's inner transport network (ie zone 1)<sup>334</sup> and are near important areas of central London for PMIs' corporate customers (primarily Harley Street and the City of London), while non-HCA hospitals are not all located in comparable areas. Whilst TLC, Edward VII and St John and St Elizabeth are located very close to HCA's Harley Street hospitals, for example, Aspen and two of the larger BMI hospitals (Blackheath and London Independent) are located outside central London's inner transport network and Bupa Cromwell is on the fringe of this network.
- 6.215 In relation to the competitive constraints imposed by PPUs, we note that HCA's business cases (see paragraph 6.217) do not suggest that PPUs represent a significant constraint on HCA across the full range of treatments/specialties HCA provides (the only exception potentially being ITU services). In one of its business cases, for example, HCA notes that [REDACTED]. This business case also [REDACTED]. This is in line with our view that NHS hospitals prioritize NHS patients over their PPU business. Moreover, our patient survey showed that patients typically do not view PPUs as a close substitute for private hospitals.<sup>335</sup> This is consistent with the shares of supply analysis discussed above. We discuss HCA's views in relation to the competitive constraints imposed by PPUs further below.

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<sup>333</sup> See paragraph 6.414 for details.

<sup>334</sup> The only possible exception is the Wellington Hospital which is located between St John's Wood underground station (just in zone 2) and Baker Street underground station (zone 1).

<sup>335</sup> When asked 'Had the hospital you attended not been available (eg say it had closed down), which other hospital would you have used?' only 10 per cent of patients answered a PPU. See [CC patient survey](#), question D6, slide 46. We note that HCA argues that our survey question is incorrectly framed. We acknowledge some imperfections with our patient survey question; however, we still believe that it helps to provide information on patients' choice showing that patients typically do not view PPUs as a close substitute for private hospitals.

- 6.216 We set out the parties' views in Appendix 6.10, Annex A. In summary, most of these views suggested that TLC is HCA's closest competitor and that overall HCA faced limited competition. AXA PPP described TLC as the only non-HCA 'must have' hospital for its large corporate clients in central London.<sup>336</sup> HCA said that TLC and Bupa Cromwell were 'probably the most formidable competitors' that it faced in central London.<sup>337</sup> TLC argued that 'there are seven elite hospitals in London' and that this consisted of TLC (one hospital) and HCA (six hospitals).<sup>338</sup> PMIs and TLC noted the difficulty that PMIs faced when trying to find alternative capacity to absorb their demand were they to delist HCA.<sup>339</sup> Finally, PMIs' and TLC's views also indicate that PPUs did not represent close substitutes to private hospitals in central London.<sup>340</sup>
- 6.217 We have reviewed business cases provided by HCA and found that, where HCA mentions central London competitors in its business cases, it only considers a small subset of such competitors closest to the facility in question (as opposed to all of HCA's central London competitors). Frequently, and in particular for cancer care, TLC is either the only competitor mentioned, one of a few competitors mentioned and/or the main competitor mentioned.<sup>341</sup> PPUs are mentioned in only a few cases.
- 6.218 On the basis of the evidence and analysis set out above, we found that HCA faces weak competitive constraints from private hospitals including PPUs located in central London. In particular, the competitive constraints imposed by PPUs in aggregate are weak. The evidence suggests that, considering insured patients, and in particular PMIs' corporate clients, the set of HCA's closest competitors is much narrower than the set of all private hospitals including PPUs in central London and that TLC, whilst being much smaller than HCA, is HCA's closest competitor. This is likely to make it very difficult for PMIs to switch a large proportion of their business from HCA to its closest competitors in central London.
- 6.219 In relation to competitive constraints from outside the market, we looked at the NHS and greater London providers.

### *Competitive constraints from the NHS*

- 6.220 As set out in paragraphs 5.12 to 5.16, we concluded that NHS funded healthcare is a separate product market from privately funded healthcare. However, we have nevertheless considered whether NHS publicly-funded services (ie excluding PPUs) were a significant competitive constraint on HCA.
- 6.221 First, we have reviewed HCA's internal documents which show HCA's general interest in exploiting 'opportunities for NHS Partnerships', NHS Trusts' 'need for private patient income', NHS budget changes, waiting lists, 'cost concerns restricting patient options in NHS', the elimination of private patients caps and the number of

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<sup>336</sup> Appendix 6.10, Annex A, paragraph 42.

<sup>337</sup> *ibid*, paragraph 16.

<sup>338</sup> *ibid*, paragraph 18.

<sup>339</sup> *ibid*, paragraphs 34–37.

<sup>340</sup> *ibid*, paragraphs 10–14 & 32. For example, AXA PPP argued that it did not consider most PPUs in London to be significant competitors and only a limited number of PPUs, notably those linked to prestigious hospitals, had the potential to remain or become significant competitors. Aviva also argued that PPUs were currently not a competitive constraint on private hospitals. TLC argued that PPUs were not close competitors because they did not offer comparable services to central London private hospitals.

<sup>341</sup> We have reviewed the 20 business cases provided by HCA in response to Question 7 of the Financial Questionnaire, which asked for business cases for all major capex (>£500,000). Unless stated otherwise, the business cases we discuss refer to these business cases. Cases that refer to TLC, often as the closest competitor, are [§§]. While our focus has been on these 20 business cases, for which we have been provided with internal documents, we note that further business cases are mentioned by HCA in [Appendix 7 of its response to provisional findings](#). TLC also plays a significant role in many of these cases.



'Londoners with PMI choosing the NHS each year' (estimated by HCA to be 40 per cent in some parts of London). This evidence suggests that HCA does monitor NHS publicly-funded activity, in terms of waiting time and restrictions to patient options in the NHS, but it also indicates that HCA's interest in the NHS is frequently directed to the private healthcare activity carried out by the NHS (ie the activity through PPUs).

- 6.222 We have in addition reviewed HCA's business cases for its major investments to determine whether HCA placed much weight on its consideration of the competitive threat from the NHS as a provider of publicly funded healthcare services (excluding PPUs). We note that the NHS did not figure prominently in HCA's discussion of the rationale behind these major investments.<sup>342</sup> [§]<sup>343</sup> Overall, HCA's business cases, whilst illustrating that HCA considers the NHS to some degree as a benchmark for its product range and to assess its business opportunities, do not show any instances of HCA investing in order to prevent its private patients from switching to the NHS as a public provider of healthcare.<sup>344</sup> The expansion of HCA's product range is aimed at creating new demand for its private business (for example, by attracting patients who previously did not have any choice other than being treated under the NHS or who are now facing reduced NHS services<sup>345</sup>). However, HCA's range and quality decisions are not indicative of the NHS imposing strong competitive constraints as HCA submitted with respect to HCA's private business (see also paragraph 6.247). This is in stark contrast to, in particular, the evidence in business cases which focus on competition between HCA and TLC surrounding cancer care (see paragraph 6.415).
- 6.223 Based on the above considerations, we found that, while HCA does take a general interest in the NHS as a public funder of healthcare services, this interest is not in terms of the NHS as a competitor to HCA but in the context of seeking to create new demand for private hospital services. Overall, we therefore found that NHS services are not a close substitute for private patient services provided by HCA and the competitive constraints exerted by the NHS on HCA are, if any, very limited.

### *Competitive constraints from private hospitals and PPUs in Greater London*

- 6.224 As we set out in paragraph 5.59, we concluded that private hospitals and PPUs located in central London should be regarded as a distinct geographic market. Nevertheless, we have considered the strength of the competitive constraints exerted by private hospitals and PPUs located in Greater London on HCA's central London hospitals. In this respect, in addition to the points set out in paragraph 5.59, we observe what follows.
- 6.225 First, in relation to patients' travel patterns, we note that, on the whole, Greater London hospitals are attracting patients who travel substantially smaller distances than private hospitals in central London.<sup>346</sup> On the other hand, a sizeable number of patients resident in Greater London and the vast majority of patients resident in central London have their treatments in central London.<sup>347</sup> We note that there are a number of possible reasons why patients resident in Greater London seek treatment in central London (and generally not the reverse). First, central London hospitals represent a more convenient location due to proximity to work rather than

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<sup>342</sup> This also holds for the business cases HCA mentioned in [Appendix 7 of its response to provisional findings](#).

<sup>343</sup> [§]

<sup>344</sup> This also applies to the business cases HCA mentioned in [Appendix 7 of its response to provisional findings](#).

<sup>345</sup> In the business cases HCA mentioned in Appendix 7 of its response to provisional findings, HCA mentions [§]

<sup>346</sup> For example, the 80 per cent catchment area is 8 miles for Greater London as opposed to 24 miles for central London and 18 miles for the rest of the UK. See Appendix 6.10, Table 4, for details.

<sup>347</sup> Appendix 6.10, Table 5.

home.<sup>348,349</sup> Second, the strong reputation of central London hospitals, in particular for complex, high-acuity services, contributes to some patients' willingness to travel longer distances to access central London hospitals.<sup>350</sup> These factors may be especially relevant for patients who are members of corporate schemes that give them access to central London hospitals (see Appendix 2.1 and Appendix 6.10, Annex A, paragraphs 41 to 43, 45 and 46).

- 6.226 We further note that if Greater London residents who go to central London for treatments were to consider Greater London hospitals to be close substitutes to central London hospitals, then this would most likely be reflected in HCA's business cases.<sup>351</sup> However, having considered HCA's business cases for its major investments, we have found only one instance of HCA taking into consideration a competitor from Greater London [§].<sup>352,353</sup>
- 6.227 Finally, as a robustness check for our analysis of shares of supply, we have also considered HCA's shares calculated including Greater London hospitals.<sup>354</sup> As set out in Appendix 6.10, paragraphs 38 and 39, we found that, in this case, HCA's share is [30–40] per cent by both inpatient and total admissions, [40–50] per cent by inpatient revenue and [40–50] per cent by total revenue. BMI is the next largest operator, with shares of [20–30] and [20–30] per cent by inpatient and total admissions respectively, and of [10–20] and [10–20] per cent by inpatient and total revenue respectively.<sup>355</sup> We also note that if vertical product differentiation is higher considering Greater London hospitals together with central London ones (as a result of the higher quality and stronger reputation of the hospitals in central London as argued by HCA<sup>356</sup>), in accordance with the CC Guidelines, revenue shares might be more informative than shares based on admissions as the former will reflect the differentiation.<sup>357</sup> This is particularly important if investments to improve quality are made over the course of several years, suggesting that it might be difficult for Greater London hospital operators to reposition themselves within a short time frame.<sup>358</sup> On a revenue basis, HCA's share, when including Greater London hospitals, is particularly high, especially for inpatient revenue. Overall, we considered that HCA's shares

<sup>348</sup> In Appendix 6.10, paragraph 18, we noted that about 1 million out of Greater London's 4.9 million residents commute to central London on a daily basis for work.

<sup>349</sup> Appendix 6.10, Annex A, paragraphs 24–27.

<sup>350</sup> This is in line with HCA's own comments on its high quality relative to competitors in London (see paragraphs 6.392 and 6.395). We note that HCA also told us that:

the CC has no basis for its conclusion that commuters to central London are somehow 'captive' to central London hospitals, despite residing outside of central London. Their choice of central London hospitals is entirely driven by the competitiveness and quality of service. Put simply, HCA must provide a compelling quality proposition to compete with Greater London hospitals and attract patients to its hospitals. If HCA's quality deteriorated, it would be very difficult to convince patients to travel past their local hospitals.

<sup>351</sup> As noted above, we have reviewed the 20 business cases provided by HCA in response to Question 7 of the Financial Questionnaire, which asked for business cases for all major capex (>£500,000).

<sup>352</sup> Similarly, the business cases HCA mentioned in [Appendix 7 of its response to provisional findings](#) refer almost exclusively to central London competitors.

<sup>353</sup> HCA business case [§].

<sup>354</sup> These are 18 hospitals, which can be found in Annex C of Appendix 6.10 and Appendix 6.6.

<sup>355</sup> We note that all Greater London private hospitals and PPU's that are mentioned by HCA as competitors to its central London hospitals are included in our shares of supply, except for seven PPU's which are not part of our list of hospitals (see Appendix 6.6). Those PPU's were excluded because six are specialized and one is smaller than our PPU revenue threshold as set out in paragraph 5.52(c). HCA mentioned ten additional hospitals which based on our definitions (see footnote 319) are located outside London. Two of these hospitals are specialized, and four are specifically mentioned by HCA as competitors for HCA's PPU in Greater London (Harley Street at Queens). The remaining four are general hospitals (Spire Bushey, Aspen's Holly House Hospital, BMI Princess Margaret and BMI Fawkham Manor) and even if we were to include them in our shares of supply for Greater and central London hospitals combined, HCA's share would drop by [0–5] per cent in terms of revenue and admissions (inpatient and total). We note that HCA did not provide evidence showing that it faces competitive pressures from any of the hospitals located outside London.

<sup>356</sup> See footnote 350.

<sup>357</sup> The Guidelines state that market shares based on revenues are the 'best "real world" measure and are particularly pertinent when products differ in quality'. See CC3, [Annex A](#), paragraph 2.

<sup>358</sup> For example, HCA argued that it had been investing heavily since its acquisition of a number of hospitals in central London in the late 1990s/early 2000s (see paragraph 6.392).

including Greater London hospitals are still high and significantly above the next highest hospital operator, BMI. We therefore found that, even having regard to the shares of supply including Greater London hospitals, the market is highly concentrated with HCA having significantly greater shares of supply than its competitors.

- 6.228 Based on the above considerations, we found that HCA faces weak competitive constraints from Greater London hospitals. This view is consistent with the views of many parties (see Appendix 6.10, Annex A, paragraphs 9 and 20 to 28).

#### *HCA vertical integration in GP practices*

- 6.229 We have also considered whether the vertical integration between HCA and certain GP practices is likely to lead to significant harm to competition in central London. As set out in our ToH7, vertical integration of this nature has the potential to affect horizontal competition between hospital operators in central London. This could happen if the vertically integrated hospital operator could influence the referral patterns of GPs, such that its rivals' hospitals can be foreclosed from patients. We have found that currently these vertical relationships between HCA and GP practices are limited in scale (ie account for a small proportion of private and NHS GPs that refer patients to HCA hospitals), and do not appear to have influenced GP referral rates (ie these have remained similar before and after the HCA acquisitions).
- 6.230 This evidence therefore did not indicate that HCA's vertical integration in GP practices is currently likely to lead to foreclosure of its rivals from patients. Nevertheless, we note two points. First, even in the absence of rivals' foreclosure, the current ownership of GP practices which are located in key central London areas for PMIs' corporate clients is likely to strengthen HCA's position relative to its competitors in central London (for example, by making it more difficult for PMIs to direct patients away from HCA). Second, we note that further acquisitions of GP practices by HCA in the future, in particular in key central London locations for PMIs' corporate clients, could raise vertical competition concerns by increasing the scale of HCA's vertical relationships with such GP practices.

#### *HCA arguments on central London analysis*

- 6.231 HCA criticized our analysis of central London. It argued that our competitive assessment was based on a flawed and incomplete market definition. It has also argued that our competitive assessment underestimated the competitive constraints in central London from PPUs and ignored competition from hospitals located outside central London, the NHS and international providers. In addition, HCA added that even setting aside its concerns on ignoring key aspects of competition, our calculations of shares of supply and capacity had mistakes and were unreliable. HCA also made a number of points on quality and range, which we summarize and address in paragraphs 6.388 to 6.403.

#### ***Geographic market definition and concentration measures***

- 6.232 In relation to our geographic market definition, HCA submitted that we had used a crude and arbitrary definition of the geographic market for central London, which was quite different from that used for outside London and also quite different from that used in the CC's other market investigations where local markets were important.
- 6.233 As stated in Section 5 (paragraphs 5.55 and 5.58), our geographic market definition for hospital services is based on the location of suppliers for all areas across the UK, including central London. In defining the set of competing hospitals which form part of

the same geographic market, we used information on (a) catchment areas based on the location of the majority of a hospital's patients; and (b) which hospitals customers (ie patients and PMIs) consider to be substitutes for each other. This is consistent with the CC Guidelines.<sup>359</sup>

- 6.234 As set out in Section 5, catchment areas are a well-established pragmatic approach to geographic market definition typically used in the presence of a large number of local markets, as it is the case in this investigation (paragraphs 5.62 and 5.63). This approach has, however, a number of widely-recognized limitations (paragraphs 5.64 to 5.67). For this reason, and given the extent of geographic and product differentiation between hospitals, we used a geographic market definition based on hospital catchment areas outside central London as a starting point only and, regardless of the precise boundaries of these geographic markets, in our competitive assessment we considered the strength of competitive constraints from hospitals within and outside the hospital catchment area (paragraph 5.68).
- 6.235 For hospitals located in central London we adopted a more comprehensive approach than we were able to do for outside central London at the market definition stage. In defining the geographic market for central London hospitals, we were able to take into account which hospitals customers considered to be close substitutes (paragraphs 5.59 and 5.60). In particular, we considered market conditions on both the supply side and the demand side and PMIs' views about the closeness of competition (which are consistent with the views expressed by some hospital operators). This evidence indicated that hospitals located in central London are regarded by customers as being close substitutes for each other and, as such, may be considered to be part of a separate geographic market. Due to the number of local areas we had to investigate outside central London, we had to take account of such factors after we had narrowed down those areas of potential concern, ie as part of our analysis of competitive effects.
- 6.236 Regarding the catchment areas for central London hospitals, we note that the fact that central London hospitals have large catchment areas (larger than, for example, Greater London hospitals (see Appendix 6.10, Table 4)) does not necessarily imply that central London hospitals are (equally) constrained by all hospitals located within their catchment areas (paragraph 5.66). In addition, we note that, recognizing the extent of geographic (and product) differentiation between hospitals, regardless of the precise boundaries of the geographic market, in our competitive assessment we considered the strength of competitive constraints from hospitals within and outside the central London area (paragraphs 5.60 and 5.61, 6.214 and 6.224 to 6.228).
- 6.237 In relation to concentration measures, HCA submitted that we used variants of two standard structural indicators of competition for everywhere except central London and that for central London we used shares of supply based on a very unreliable geographic market boundary, thereby producing the 'crudest' form of structural indicator. HCA also said that, in the absence of a robust market definition, we should not rely on shares of supply.
- 6.238 As regards the concentration measures used for the purpose of our filtering exercise, we make the following observations. First, we note that we used two concentration measures, LOCI and fascia count (within a hospital's catchment area), additively for all hospitals, including hospitals located in central London. Our approach to filtering is set out in paragraphs 6.147 to 6.158 and in Appendix 6.5. In relation to fascia count, we are aware that there are several fascias in central London. However, this does

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<sup>359</sup> CC3, paragraphs 145 and 148 .

not necessarily imply that all these fascias are exerting similar competitive constraints on each other. This is a widely-recognized limitation of fascia count as a concentration measure (see Appendix 6.5, paragraph 13). In relation to LOCI, we observe that five central London hospitals, of which four are HCA's, were identified by the LOCI filter (see paragraph 6.159). In addition, we note that filters are used as a screening device, in the presence of a large number of hospitals, to exclude hospitals which appeared not to be a concern and therefore did not require further analysis (see paragraph 6.158). We were not precluded from assessing hospitals (or local areas) not identified by the filters if further evidence and analysis indicated that this would be appropriate (see Appendix 6.5, footnote to paragraph 1). In this respect, we noted the widespread concerns expressed by PMIs and some hospital operators in relation to the lack of competition in central London (see paragraph 6.202). Finally, we observe that, given the size of the catchment areas of the four HCA hospitals identified by the LOCI filter and the substantial overlap between these, and between these and HCA's other hospitals in central London, in our competitive assessment we would have analysed these four HCA hospitals together with the other HCA central London hospitals even if we had not adopted a market definition based on central London. Therefore, in our view our competitive assessment of HCA's central London hospitals is consistent with the competitive analysis in our local assessments of hospitals of concern outside central London.<sup>360</sup>

- 6.239 As regards HCA's submissions on the use of shares of supply as a measure of market power, we note the following points. We consider our geographic market definition for central London hospitals to be robust and, as a consequence, market shares to be a valid indicator to use in the assessment of firms' market power, which is consistent with the CC Guidelines.<sup>361</sup> We further note that shares of supply are only one of the factors we have taken into account in our assessment of competitive constraints within the market we have defined—other factors being product range and quality; locations of hospitals; the views of the parties and their internal documents. In addition, we have also taken account of competitive constraints from outside the market (see paragraph 6.203). We further address HCA's arguments in relation to shares of supply in paragraphs 6.248 to 6.253.

## **PPUs**

- 6.240 HCA argued that we underestimated competitive constraints from PPUs in central London. In particular, HCA argued that its internal documents acknowledged the threat HCA faces from PPUs<sup>362</sup> and that insurers had made comments indicating that PPUs in London were not weak competitive constraints.<sup>363</sup> HCA further noted that PPU capacity was not reflected in the CC's analysis of shares of capacity, and, according to Laing & Buisson, PPUs accounted for 25 per cent of total bed capacity in central London. HCA moreover pointed out that PPUs were set to expand in the near future.
- 6.241 We note that PPUs are included in our market definition and competitive assessment for central London (as well as for outside central London). We agree with HCA that PPU capacity should be included in our capacity share calculations, but we found

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<sup>360</sup> The HCA hospitals identified by the LOCI (revenue share) filter were the following: Lister Hospital, Portland Hospital, Princess Grace Hospital and Wellington Hospital.

<sup>361</sup> CC3, paragraphs 101, 186 and Annex A, paragraph 1.

<sup>362</sup> For example, HCA noted that PPUs could utilize the NHS's pre-existing services to deal with more complex cases, and have low capital expenditure threshold affording them a substantial competitive advantage.

<sup>363</sup> For example, AXA PPP describes the Royal Marsden's PPU as an 'elite' hospital. With regard to PruHealth's and Simplyhealth's hospital networks, a number of London-based PPUs are only available to patients on its top-end network products. In its brochure for corporate clients, Aviva refers to the PPUs in its Trust Care network as comprising 'excellent private patient units of NHS Trust and partnership hospitals'.

data limitations for some of the capacity measures used (see paragraph 6.209). On the basis of overnight bed capacity using Laing and Buisson's data, we found that HCA's share of capacity is still high at 47 per cent.<sup>364</sup> Our assessment of the competitive constraints imposed by PPUs is set out in paragraphs 6.205, 6.210 and 6.215 to 6.218.

- 6.242 Regarding the potential expansion of PPUs, we discuss this issue in more detail in Appendix 3.1 but note that the extent of PPU expansion remains uncertain, and the expansion would have to be very significant to fundamentally alter the results of our analysis. We also note that HCA currently manages one PPU in central London, has won a tender to operate a further large PPU at Guy's NHS Trust and could be successful in winning further tenders for PPU contracts in the future, as its higher prices in central London may allow it to outbid its rivals for PPU contracts in the same area. This would further strengthen HCA's position in central London.

### **Greater London**

- 6.243 HCA argued that the CC underestimated the competitive constraint from hospitals in Greater London. It argued that the CC did not consider what travel patterns would look like if the competitive offering of the central London hospitals worsened. In HCA's view, the CC assumed in particular that customers resident outside central London (ie about [X] per cent) were not sufficient to prevent HCA from being able to exploit its supposed market power in relation to central London customers.<sup>365</sup> HCA provided a list of private hospitals and PPUs outside central London available to patients, which it considered as competitors to its central London hospitals.<sup>366</sup> It further argued that the specialty mix in central and Greater London was broadly similar and that, while there were some differences, this was no basis to conclude that central and Greater London were separate geographic markets.

- 6.244 We have addressed HCA's points on Greater London hospitals in paragraphs 6.224 to 6.228.

### **NHS**

- 6.245 HCA argued that the CC underestimated the competitive constraint from the NHS. In particular, HCA argued that the competitive constraint that the NHS placed on HCA's business was illustrated by HCA's interest in NHS activity as evidenced in HCA's internal documents. HCA argued that the NHS, and in particular its teaching hospitals, provided high-quality services, especially for cases involving multiple specialties. HCA argued that in many cases, while it was the first private provider to offer a particular treatment, this treatment was already being offered by the NHS. Moreover, it argued that taking account of the NHS as a source of supply was particularly important for CCL3.<sup>367</sup>

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<sup>364</sup> Similarly to our calculations of shares of supply, we note that we have only included data for central London PPUs listed in Appendix 6.10, Annex B. Our estimate of HCA's share of overnight bed capacity, at 46.5 per cent, is slightly higher than HCA's own estimate, calculated using Laing and Buisson 2011/12 data, at 43.7 per cent. Based on our calculations, the reason for this difference appears to be that HCA has included PPUs in Greater London.

<sup>365</sup> HCA stated that the CC's catchment area methodology showed that HCA hospitals attracted patients from Greater London or even further and there were a number of private hospitals and PPUs in Greater London that represented a significant constraint.

<sup>366</sup> HCA added that PMIs marketed both central and Greater London providers to their policyholders, which confirms that it considers hospitals outside central London as viable, competitive alternatives to HCA's central London hospitals.

<sup>367</sup> HCA told us that we had ignored the important role of PMIs in driving patient substitution between the NHS and private hospitals, including through means such as the 'six-week rule' and cash-back incentives.



- 6.246 A number of HCA's comments on the NHS are addressed in paragraphs 6.220 to 6.222 and our conclusions on competitive constraints exerted by the NHS are set out in paragraph 6.223. HCA's point in relation to the NHS as a source of supply for CCL3 is addressed in paragraph 6.248.
- 6.247 In relation to HCA's comments on the quality differences between its hospitals and NHS hospitals, we note that HCA's evidence is mixed in this respect. On the one hand, HCA told us that NHS hospitals (and in particular NHS teaching hospitals) provided high-quality services where ITU services and/or multiple specialties were involved. On the other hand, we note [§]. This suggests that HCA non-ITU services are even more superior when compared with those provided by the NHS (rather than by the PPUs).<sup>368</sup> In this regard, we note that [§], making a clear distinction between the NHS and the private sector. We consider that where the NHS is considered by HCA to be high quality, this is likely to be more for clinical outcomes than other dimensions of quality of service (eg waiting time and customer service).<sup>369</sup> The significant quality differential HCA claims to exist between HCA and NHS hospitals' overall product offer is consistent with our conclusion that publicly-funded NHS services are not a close substitute for private patient services provided by HCA.

### ***Shares of supply and capacity***

- 6.248 In relation to our shares of supply and capacity analysis, in addition to the points set out in paragraph 6.237, HCA further argued that shares should be based on capacity and not revenue. HCA mentioned that shares based on revenue and admissions were wrong because they penalized successful hospitals, while capacity was the correct measure as it reflected the ability of consumers and health insurers to choose. It added that revenue was even more misleading because prices may reflect quality, revenue shares penalize hospitals that had sicker patients who were more costly to treat, and the proposed CC changes to redesign the market would have a double effect on revenue shares as, according to the CC's assessment of price benefits, they would lead to price corrections. HCA considered that there was sufficient capacity at non-HCA hospitals to absorb the volume of AXA PPP or Bupa patients currently treated at HCA hospitals. HCA further considered that the shares of supply of CCL3 were inflated and did not measure the share of supply of CCL3 in central London because the computed shares of supply included all treatments and specialties, instead of considering only those requiring CCL3. HCA added that critical care facilities in the NHS were available to use by not only the associated PPU, but also any other hospital operator and should be included in the measures of critical care capacity. HCA further argued that shares of supply by specialty were not meaningful as most of the data on patient admissions was missing and the CC failed to include a number of central London private hospitals and PPUs.<sup>370</sup>

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<sup>368</sup> We note that the PMIs, in particular AXA PPP, Aviva and WPA, did not consider PPUs to be competitive constraints for HCA (see Appendix 6.10, Annex A, paragraphs 10, 13 & 14).

<sup>369</sup> HCA, for example, told us that with respect to UK self pay patients, they choose to pay for private treatment instead of using the free NHS alternative. This choice is based on the desire to receive a better quality of care, e.g. a greater choice of treatments, faster and more joined-up care and better customer service. If private hospitals failed to maintain this quality differential, private hospitals would simply be unable to attract UK self pay patients and that 'for PMI patients, their insurance coverage means that, at the point of seeking care, quality, rather than price, is their main consideration'.

<sup>370</sup> HCA also argued that we underestimated competitive constraints from international providers. We have not seen evidence of HCA's insured patients in the UK considering international providers as alternatives to HCA. In paragraphs 6.406(b) to 6.408, we consider the possibility of international business having an impact on HCA's decisions surrounding quality and range. HCA also told us that in certain of our measures of shares of supply, we had included revenues from international patients but not international providers. Excluding international patients from our data for central London has little effect on HCA's share, eg HCA's share of central London total admissions does not change (40–50] per cent) and HCA's share of central London total revenue drops by [§] [0–5 per cent] ([50–60] to [50–60] per cent).

- 6.249 We address HCA's comments on our geographic market definition and the use of market shares in paragraphs 6.232 to 6.239. As a general point, we note that the CC Guidelines suggest that the CC will use several indicative measures so as to understand fully how a market is operating.<sup>371</sup> We have therefore considered shares based on revenues, volumes and capacity.<sup>372</sup>
- 6.250 With regard to the ability of non-HCA hospitals to absorb AXA PPP and Bupa volumes currently treated at HCA hospitals, we note that HCA's analysis takes no account of the existing number of patients in rival hospitals (reducing the amount of available capacity), the availability of consultants to perform procedures and the capacity situation at peak times of year, so in our view this analysis does not demonstrate that substitution between HCA and non-HCA hospitals is feasible for Bupa and AXA PPP. We set out our conclusions in this respect in paragraph 6.218.
- 6.251 Regarding shares of supply for providers of CCL3, we first note that hospital operators, including HCA, told us that there was not a one-to-one correspondence between treatments and/or specialties and CCLs, and that the decision to admit a patient into critical care depends not only on the type of treatment (and its complexity) but also on a variety of patient-specific factors including, for example, co-morbidities. They added that although some complex treatments might indicate the need for critical care, complex treatments need not require critical care and treatments that were not complex might end up needing critical care. We also note that to the extent that we have included in our share calculations specialties that typically do not require CCL3 for all operators we are comparing, it is likely that we have underestimated HCA's share of CCL3 treatments.<sup>373</sup> Moreover, our analysis of HCA's position in more complex segments of the market was not only based on shares of supply among hospitals providing CCL3. We have looked at other measures such as shares of supply by specialty for oncology and cardiology and shares of supply for tertiary treatments. In addition, we do not consider that NHS capacity should be added to the shares of capacity in terms of CCL3 beds. We are aware that the NHS critical care units may be used by all patients and that there are agreements in place between private operators and NHS hospitals for that purpose. However, we note that the NHS prioritizes its own patients and that, to the extent that having critical care units represents an element of differentiation between private providers (for both PMIs and patients), as HCA claimed, it is appropriate to calculate shares among private providers which have critical care.
- 6.252 Regarding our specialty-level analysis, we note that the missing data in any given specialty is estimated to have no material impact on the results for each specialty.<sup>374</sup>

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<sup>371</sup> CC3, [Annex A](#), paragraph 1.

<sup>372</sup> We note that shares based on revenues are relevant whenever there is vertical product differentiation, which is what HCA claims, ie that its quality is higher than that of its central London rivals. This is recognized in the CC3, [Annex A](#), paragraph 2. See in this regard our considerations in relation to shares of supply in Greater London in paragraph 6.28. Given that we did not find evidence of substantial quality differentiation in central London, we note moreover that our finding that HCA charges higher prices may itself be an indication of the lack of spare capacity at HCA's close competitors, and that this is captured in our shares of revenue.

<sup>373</sup> Shares are likely to be inflated for those operators which have more of their specialties that do not require CCL3 and shares are likely to be underestimated for operators which have more of their specialties that do require CCL3. HCA is likely to be in the latter group of hospitals.

<sup>374</sup> As noted in Appendix 6.10, Table 8, data is not available for one BMI hospital for obstetrics and gynaecology, trauma and orthopaedics and urology (total admissions at this hospital account for less than [§] per cent of total admissions in central London); data is not available for one BMI hospital for ophthalmology and two BMI hospitals for dermatology (the missing data for each BMI hospital is estimated to be less than [§] per cent of its total admissions in central London); data for Aspen is not available for ophthalmology and rheumatology (the missing data for Aspen is estimated to be less than [§] per cent of its total admissions in central London); data is not available for some PPU's for some specialties (the missing data for the six PPU's combined is estimated to be around [§] per cent of total admissions in central London).



6.253 Finally, we point out that the private hospitals and PPUs that HCA claimed were missing in our analysis are located in Greater London and not in central London (see lists of hospitals in Annex B of Appendix 6.10 and Appendix 6.6).<sup>375</sup>

### *Conclusions on competitive constraints in central London*

6.254 We found that the competitive constraints exerted on HCA by other private hospitals including PPUs located in central London are weak (see paragraph 6.218). PPUs in aggregate, in particular, are a weak constraint, and the future expansion of PPUs does not appear likely to substantively change this conclusion (see paragraph 6.242). Considering insured patients, and in particular PMIs' corporate clients, the relevant competitive constraints on HCA arise from a narrower set of private hospitals including PPUs in central London, in particular from TLC, and these constraints are weak (see paragraph 6.218). We also found that Greater London private hospitals including PPUs impose weak competitive constraints on HCA and that the NHS imposes, if any, very limited competitive constraints on HCA (see paragraphs 6.223 and 6.228).

6.255 It is our view that HCA could be successful in winning further tenders for PPU contracts in central London, and this would further strengthen HCA's position in central London (see paragraph 6.242). Moreover, further acquisitions of GP practices by HCA, in particular in key central London locations for PMIs' corporate clients, could raise vertical competition concerns by increasing the scale of HCA's vertical relationships with such GP practices (see paragraph 6.230).

## **Market outcomes**

### *Self-pay prices*

#### *Introduction*

6.256 We considered the evidence on self-pay pricing and examined whether and to what extent the prices charged to self-pay patients indicate that, all else equal, private hospitals including PPUs charge higher prices in local areas where they face weaker competitive constraints (ie where local concentration is higher). In this section, we provide a summary of our methodology, results, comments from the parties and our responses. The section ends with our conclusions. The full details of our analysis of self-pay prices are provided in Appendix 6.9.

6.257 As part of our assessment of self-pay market outcomes we have also reviewed qualitative evidence submitted by the parties, including hospital operators' views and internal documents (see Appendix 6.9, Annex B). The evidence showed that it is common in the industry to delegate self-pay pricing decisions to individual hospitals, that hospitals typically collect information on prices charged by local competitors, and that the knowledge of local competitive conditions is a common consideration in hospitals' self-pay pricing strategies. The evidence also showed instances of

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<sup>375</sup> HCA submitted that we failed to include a number of private hospitals and PPUs in central London in our shares of supply and capacity analyses reported in Appendix 6.10, Tables 6–11. HCA argued that in total, we did not gather information from 15 of the 44 facilities listed in Appendix 6.6—such as Aspen's Highgate and Parkside facilities, alongside highly-regarded PPUs, including the Royal Marsden and Imperial College Healthcare NHS trust. We disagree with HCA's view. We have included a total of 26 private hospitals and PPUs located in central London (see Appendix 6.10, Annex B). We note that Aspen's Highgate and Parkside is located in Greater London, and the Royal Marsden and Imperial College Healthcare PPUs are included in our analysis (we provide details of any exclusion of certain providers in our share of supply analysis due to data limitations in Appendix 6.10). In relation to PPUs, HCA submitted an analysis of PPU revenues showing that PPUs accounted for around 27 per cent of total private patient revenues in central London. We note that HCA's analysis includes PPUs that are located in Greater London.

hospitals adjusting their self-pay prices directly in response to the behaviour of local competitors (eg entry or expansion).

### *Methodology*

- 6.258 The principal aim of our analysis was to compare self-pay prices at a number of hospitals each facing a different degree of local competitive constraints. To do this, we used a standard statistical technique known as regression analysis, or in this context price-concentration analysis (PCA). This technique allows for comparisons to be made between self-pay prices and local concentration on a like-for-like basis.
- 6.259 Our analysis focused on self-pay inpatient treatments provided at hospitals owned by the five largest hospital operators in the UK over the period 2009 to 2012. These operators are BMI, HCA, Nuffield, Ramsay and Spire.<sup>376</sup> We focused on inpatient treatments (as opposed to day-case or outpatient treatments) for two related reasons. First, as our analysis focused on general private hospitals and PPUs providing inpatient care, we excluded a substantial number of day-case-only clinics (see paragraph 5.47). It follows that the concentration measures we used were more accurate in reflecting local competitive constraints for inpatient treatments. Second, the provision of inpatient care is offered by fewer providers and is therefore more concentrated than the provision of day- and outpatient care (see paragraph 5.48) and, other things being equal, we would expect the effect of concentration on prices to be more pronounced for inpatient care.
- 6.260 We selected four inpatient treatments to focus our analysis on. These treatments were: hip replacement, knee replacement, prostate resection and gall bladder removal. We selected these treatments on the basis that they are the four highest volume self-pay inpatient treatments in our cleaned data set. From the 54 inpatient treatments included in our cleaned data set, the four treatments account for around 57 per cent of admissions. On this basis, we therefore considered the four treatments sufficiently representative of self-pay inpatient treatments for the purposes of our analysis.<sup>377</sup> The parties have disputed the representativeness of our data and we discuss this later in paragraph 6.268.
- 6.261 To perform the analysis, we used one measure of self-pay prices and two measures of local concentration. We defined the price measure as the total amount paid by a self-pay patient for inpatient hospital services associated with a single treatment during a single hospital visit, excluding the consultant fees and fees for ancillary items (eg telephone calls, food and newspapers). We have used two measures of local concentration which we refer to as LOCI and fascia count; these measures are consistent with those applied in our initial filtering exercise (see Appendices 6.4 and 6.5).<sup>378</sup> Our analysis also took account of differences between each hospital's patient mix and local supply and demand conditions.

### *Results*

- 6.262 Our results are based on two econometric methods—Ordinary Least Squares (OLS) and Instrumental Variables (IV). These methods differ in the way that they take account of factors other than local concentration. OLS accounts for the factors that we can measure and include in the analysis (eg patient characteristics, local supply

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<sup>376</sup> The sample of data available for HCA was significantly smaller in size than the other four hospital operators.

<sup>377</sup> We also tested whether our results were robust to the inclusion of all 54 treatments and found similar results.

<sup>378</sup> The LOCI measure used in this analysis is a weighted average market share of the hospital based on self-pay admissions, and the fascia count is the number of rival hospital fascias in three different distance bands around the hospital.

and demand conditions), while the IV method also accounts for factors that are not measured in the available data. With both methods, we have (separately) considered the use of the two alternative concentration measures. We discuss this in detail in Appendix 6.9.

- 6.263 We found that the results using both the OLS and IV methods provided evidence of a relationship between self-pay prices and local concentration—hospitals in local areas where local concentration is higher charge higher self-pay prices. This was the case for the results using the IV method with either concentration measure, and the OLS method using the LOCI concentration measure.<sup>379</sup>
- 6.264 Our results provided estimates of the magnitude of the relationship between self-pay prices and local concentration. We considered the results based on the IV method to provide the most reliable estimate of this magnitude (see Appendix 6.9, paragraphs 52 to 65). These results indicated that self-pay prices are on average lower by around 3 to 9 per cent when an additional competitive fascia is present.<sup>380</sup> If a particular assumption used when applying the IV method does not hold, we considered that under a weaker assumption these estimates may understate the magnitude of the relationship (see paragraph 6.272 below and Appendix 6.9, paragraphs 85 to 87).
- 6.265 We carried out an extensive sensitivity analysis and a number of tests to check how robust our analysis was to modifications to the data and our assumptions.<sup>381</sup> The sensitivity analysis involved testing the impact of changing the data, the choice of treatments analysed, the choice of model specification and considering the impact of measurement error. Overall, these tests confirmed that our conclusions are robust to these issues.
- 6.266 We also carried out further analysis to assess whether there are material differences in the relationship between self-pay prices and local concentration between the five main hospital operators.<sup>382</sup> This analysis involved estimating our statistical model separately on the data provided by each operator (rather than using the data from all operators combined). While we had some concerns that our ability to analyse this issue was constrained by the availability of data,<sup>383</sup> the results of this analysis did not suggest that the price-concentration relationship was different between the operators. We noted that this result was consistent with our review of qualitative evidence which also did not reveal material differences in self-pay pricing strategies of the five hospital operators (see Appendix 6.9, Annex B). As a result of the quantitative and qualitative work, we considered that the main results described above are sufficiently representative for BMI, Nuffield, Ramsay and Spire. We also considered the main results sufficiently representative for HCA because our qualitative work showed that HCA was not materially different from the other four operators in its behaviour regarding self-pay price setting and local competition.<sup>384</sup>

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<sup>379</sup> The results using the OLS method with the fascia count concentration measure are discussed in Appendix 6.9.

<sup>380</sup> The estimated coefficient for LOCI is  $-0.1717$ . A change in LOCI of 0.2 is approximately equivalent to a change in competitive fascias from 1 to 2, and a change in LOCI of 0.5 is approximately equivalent to a change in competitive fascias from 0 to 1. We therefore take the estimated coefficient from the LOCI models using IV to show that one additional fascia leads to prices that are lower by between 3.4 and 8.6 per cent. The equivalent estimate from the fascia count models show that one additional fascia leads to prices that are lower by 5.3 per cent, which lies in the same range.

<sup>381</sup> See Appendix 6.9, paragraphs 88–130.

<sup>382</sup> See Appendix 6.9, paragraphs 132–143.

<sup>383</sup> Analysis at the operator level relies on comparisons between self-pay prices and local concentration among only those hospitals belonging to a single operator. As a result the number of comparisons between price and concentration is significantly lower than the number of comparisons across all operators (and their hospitals). We therefore considered the operator-level approach to be generally weaker. We carried out this analysis for BMI, Nuffield, Ramsay and Spire. We did not carry out the analysis for HCA because the sample of data available for HCA was too small.

<sup>384</sup> We did not estimate the price-concentration relationship for HCA because the available data sample was too small (see paragraph 6.269).

- 6.267 Over the course of this investigation we consulted with hospital operators and PMIs on our PCA work.<sup>385</sup> We considered the parties' comments in detail and, where appropriate, made improvements to our analysis.<sup>386</sup> The main arguments raised by the parties in relation to our work are as follows:
- (a) the treatments and data sample used in our analysis are not representative of the self-pay market or of the business of certain operators;
  - (b) the LOCI measure of local concentration is flawed as either a measure of market share or as a measure of market power;
  - (c) our analysis does not account (or accounts very poorly) for a range of factors (eg differences in local supply- and demand-side factors, or differences in patient circumstances) that influence self-pay prices and this biases our OLS estimates;
  - (d) our IV method does not satisfy the necessary assumptions and the estimates are therefore invalid or likely to be biased; and
  - (e) our analysis does not take sufficient account of the differences in the price-concentration relationship between hospital operators, treatments or regions, and the results do not apply to certain operators.
- 6.268 In response to the parties' arguments about the representativeness of our data, we stress that the four treatments we have analysed are the highest volume treatments among self-pay inpatient treatments in our cleaned data set. While certain treatments were excluded from this cleaned data set, these exclusions were made to ensure the data that we did analyse was indeed representative of the segment of the self-pay industry we sought to assess (eg we excluded outpatient and day-case treatments, inpatient treatments that were often also performed as a day-case treatment, cosmetic or non-acute inpatient treatments, and years prior to 2009). Moreover, when we have made exclusions to the data for other reasons, we have tested the robustness of our results to these exclusions. For example, our results are robust to the inclusion of every inpatient treatment in our data set (in total 54 treatments), and to the inclusion of segments of certain irregular patient episodes that were excluded in our data cleaning process (eg episodes with prices that appear extreme). Finally, we noted that while the parties argued that the sample was not representative, they made no attempt to provide any indication of how our data set could be improved, or which alternative treatments should have been considered. Overall, we are satisfied that our results are representative of self-pay inpatient treatments, and we discuss separately the applicability of our results to outpatient and day-patient treatments in paragraph 6.275.
- 6.269 In addition to the above, HCA argued that the omission of 55 per cent of invoices in London meant our measures of concentration in this area were flawed and the data sample was too small. It argued that this meant that the results of our analysis were not representative of London.<sup>387</sup> In response to this, we first note that any missing

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<sup>385</sup> BMI also submitted its own econometric analysis that estimated the differences in self-pay price and non-price outcomes between BMI hospitals classified as either solus or non-solus. We interpreted the results of the BMI analysis for self-pay price outcomes to be consistent with the results of our analysis, although due to our concerns over certain methodological issues with the BMI analysis, we did not put weight on the BMI analysis (see Appendix 6.9, paragraphs 144–151).

<sup>386</sup> For example, we modified the treatments that our analysis focused on, improved the way in which certain control variables are calculated, and dropped two instrumental variables that were originally used in our IV method. These and other responses to the parties' comments are covered in detail in Appendix 6.9.

<sup>387</sup> [HCA response to provisional findings, Appendix 2: Self-pay PCA](#), paragraphs 2.25–2.27.

invoices may affect the LOCI measure of concentration (discussed in Appendix 6.4 for insured data, and Appendix 6.9 for self-pay data) but will not affect the fascia count measure of concentration, and we find that our PCA results are consistent using either of these measures of concentration. The consistency between the results using these two measures of concentration suggests that the missing invoices did not materially affect our analysis. In relation to the size of the HCA data sample, we agree that it is smaller than for other operators included in our analysis, and there are several reasons for this,<sup>388</sup> however, we considered it to be the appropriate data sample and, where possible, we have tested that our analysis is robust to making the data sample more inclusive.

- 6.270 In response to the parties' arguments about LOCI, we paid careful attention to the arguments made and concluded that this measure is appropriate for the purposes of the PCA in this inquiry. The more technical points regarding LOCI are addressed in Appendix 6.4. Here we note two points that we think provide support and validation for the use of LOCI in the PCA in this investigation. First, the purpose of the PCA was to test statistically whether LOCI and self-pay prices are systematically related. If, as the parties have argued, LOCI was a meaningless measure then we would expect our PCA to have rejected the hypothesis that LOCI is related with self-pay prices. However, this is not the case. For self-pay inpatient treatments, the data and our analysis show that there is an empirical relationship between the LOCI measure and price outcomes. Second, we found that the results of our PCA (ie the size of the price effect) were consistent when either LOCI or fascia count are used as the measure of local concentration. While there is less precedent for LOCI being used in PCA studies, fascia count has been very widely used and the consistency in our results using these two different measures provides additional support for the use of LOCI.
- 6.271 In response to the parties' arguments that there may be factors that influence self-pay prices and cause bias in our OLS estimates, we considered the possible factors omitted from our analysis and the bias that this might have induced. We discuss this at length in Appendix 6.9 (paragraphs 52 to 65). We considered it plausible that there are omitted demand-side factors affecting our OLS estimates.<sup>389</sup> These omissions may imply that our OLS estimates understate the magnitude of the relationship between self-pay prices and local concentration. As explained in paragraph 6.264, we therefore relied on our IV results, which account for these omitted factors, to conclude on the magnitude of the relationship.
- 6.272 In response to the parties' arguments that our IV estimates are invalid, again we gave this detailed consideration as set out in Appendix 6.9 (see paragraphs 70 to 79). In response to the parties' arguments, we dropped two instrumental variables (distance to closest rival hospital and distance to closest own hospital) and we considered the validity of our results if we were to use an alternative and weaker assumption for the other instrumental variable (insured LOCI). Regardless of which assumption is used our IV results remain valid, but may understate the magnitude of the relationship. We were not able to further assess the size of this potential under-

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<sup>388</sup> First, HCA treats fewer self-pay patients than BMI, Nuffield and Spire. This will mean HCA has a relatively small data sample compared with these operators irrespective of other considerations. Second, the HCA data that we received was in a different format to the other hospital operators' data, and this meant that a higher proportion of data was not usable in our analysis. When processing HCA's data we followed their guidance. The details of our data processing are set out in Appendix 6.9, Annex A. Third, when we cleaned the data, we identified a higher proportion of data for HCA, as compared with other operators, as irregular (eg having prices that were very large or very small). These irregular patient episodes were excluded from our main analysis, although we found that our results are robust even when these irregular episodes are included. Fourth, our main analysis focused on four treatments, which means the HCA data sample (and other operators' data samples) is smaller than if we had used all treatments, but we found that our results are robust if all treatments are included in the analysis.

<sup>389</sup> We considered that if any supply-side factors are omitted, they are likely to be small and unlikely to materially affect our estimates.

estimate and therefore we interpreted the range presented in paragraph 6.264 as a lower bound of the magnitude.

- 6.273 In response to the parties' arguments that our analysis has neglected differences in the price-concentration relationship between hospital operators, treatments and regions, we do not consider that these issues are a substantive concern and consider that our analysis has addressed each issue. Regarding treatments, our approach was to pool together the four treatments under analysis. However, we tested the robustness of our results when our analysis is applied separately for each treatment and also collectively for all inpatient treatments in our data set. The results of these tests did not raise any concerns in relation to our main results. In relation to regions, we did not see a good economic rationale for there to be differences in this regard and our tests did not indicate any reason for concern. Finally, in relation to operators, we estimated the price-concentration relationship separately for each hospital operator to the extent that our data allowed and, as noted in paragraph 6.266, we did not find evidence of material differences between the operators.<sup>390</sup>

#### *Conclusions on self-pay prices*

- 6.274 The results of our PCA show that there is a causal relationship between local concentration and self-pay prices for inpatient treatments. Private hospitals in more concentrated local areas charge higher self-pay inpatient prices than hospitals in less concentrated local areas. Our review of the qualitative evidence, which included private hospital operators' views and a wide range of internal documents (see Appendix 6.9, Annex B), indicated that the behaviour of private hospital operators is consistent with this result. We therefore conclude that private hospitals including PPUs, on average, currently charge higher self-pay prices for inpatient treatments in local areas where they face weaker competitive constraints.
- 6.275 We have not estimated an analogous relationship for self-pay outpatient or day-case treatments. As noted in paragraphs 5.48 and 6.259, the provision of inpatient care is generally more concentrated than the provision of day- and outpatient care. However, our review of qualitative evidence has not indicated that the operators providing inpatient care have a different pricing strategy for day-case or outpatient treatments than for inpatient treatments, ie prices for self-pay treatments in general are set taking into account local conditions. In addition, as noted in paragraph 5.48, some day-patient and outpatient treatments (for example, because of their complexity) are likely to be provided within an inpatient care setting by providers of inpatient care. Also, outpatient visits are often ancillary to inpatient and day-case treatments, either as part of the diagnostic stage or as follow-ups, and may frequently take place in the same hospital where the main inpatient or day-patient treatment has taken or will take place. As a result, some day-patient and outpatient treatments are likely to be subject to similar competitive conditions as those arising in the provision of inpatient treatments. We therefore consider that the price-concentration relationship for some day-case and outpatient treatments will be similar to the relationship we have found for inpatient treatments.

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<sup>390</sup> As noted in paragraph 6.266, we did not estimate the price concentration for HCA because the available data sample was too small. However, our review of HCA's submissions and internal documents did not reveal material differences between HCA's self-pay pricing strategies and those of the other operators.

## ***Insured prices***

### *Introduction*

- 6.276 'Insured prices', ie the prices charged by hospital operators to PMIs for treatments provided to insured patients, are an outcome of bilateral negotiations between hospital operators and PMIs. During these negotiations, discussions typically focus on the price of the overall bundle of a hospital operator's services (ie the associated revenue), with relatively little focus on the price of individual treatments. The prices of individual treatments are generally not set at the hospital level, but are the same across the hospital operator's portfolio of hospitals contracted with the PMI, thus reflecting some average price of each treatment across these hospitals.
- 6.277 This section sets out our analyses of insured prices and is structured as follows. First, we set out the framework and the economic principles underlying our analysis of bargaining and insured price outcomes. Secondly, we outline the relevant evidence from the internal documents and the parties' submissions. We then present our empirical analysis of insured prices, including our response to the comments received by the parties, and discuss the parallels between insured and self-pay price analyses. We finally set out our considerations around PMIs' buyer power. The conclusions on our analyses of insured prices are presented at the end of this section.

### *Economic framework*

- 6.278 The provision of private hospital services and the provision of private medical insurance are highly concentrated at the national level. For private hospital services, we identified many local areas across the UK, including central London, which are characterized by high concentration and weak competitive constraints between private hospitals including PPU's (hospitals of concern).
- 6.279 In line with this high concentration, neither the hospital operators nor the PMIs appear to be 'price takers' in the sense that they must accept a price set by the other party. Similarly, neither of the two appears to be in a position to make 'take-it-or-leave-it offers' with respect to insured prices. This is consistent with the observation that insured prices are bilaterally negotiated rather than list prices, as it is broadly the case in the self-pay segment.
- 6.280 Economic principles suggest that, in a bilateral bargaining context, the bargaining outcome (eg the negotiated price) depends on the alternatives, referred to as outside options, available to both negotiating parties in the event that an agreement is not reached.<sup>391</sup> Typically an agreement is reached if both parties receive some financial benefit above and beyond their outside options. We refer to this financial benefit as a party's share of the bargaining surplus.<sup>392</sup>
- 6.281 This is consistent with the CC Guidelines which state that: 'In some markets prices are in effect determined by the relative bargaining power of sellers and buyers'.<sup>393</sup> The CC Guidelines also recognize the effect of buyers' outside options on their

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<sup>391</sup> Outside options are the best alternative profits the parties can earn in the event of a temporary or permanent breakdown in negotiations. For example, in the event of a delisting, consumers will have to choose whether to stay with their hospital operator (and switch PMI) or whether to stay with their PMI (and switch hospital operator). To the extent that consumers stay with the hospital operator, this strengthens the hospital operator's outside option and, likewise, to the extent that consumers stay with their PMI this strengthens the PMI's outside option.

<sup>392</sup> The way the bargaining surplus is shared depends on a party's degree of patience, which is related to their financial strength, and possibly other factors such as negotiating ability.

<sup>393</sup> CC3, [paragraph 176](#).

bargaining power and hence on the bargaining outcome (as we discuss in more detail below). They state that ‘The relative importance to each buyer and supplier of its business with the other party is a key factor, and the strength of the buyers’ “outside options”, ie their alternative strategies in relation to the relevant product, is often the crucial determinant of countervailing buyer power.’<sup>394</sup> In accordance with the CC Guidelines, we define as ‘countervailing’ the buyer power which prevents the exercise of market power.<sup>395</sup>

- 6.282 Given the dependence of the bargaining outcome on parties’ outside options, all else equal, the less (more) attractive a PMI’s outside option, the higher (lower) will be the negotiated price. A similar but reverse relationship holds for the hospital operator—it will receive a higher (lower) price the more (less) attractive its outside option.
- 6.283 Considering a PMI, its outside options in a negotiation with a hospital operator are given by the hospitals to which the PMI can switch its customer base in each local area in case of no agreement with the hospital operator (ie full delisting<sup>396</sup>). In other words, the degree of substitutability between local hospitals determines the outside options of the PMI and, as such, it is related to the price negotiated between the PMI and the hospital operator. Local concentration can be used as a proxy for local substitutability. If local concentration is higher, it will be more difficult for the PMI to find substitutable hospitals in that local area, it will thus have less attractive outside options and agree to higher insured prices.<sup>397,398</sup> In what follows, we refer to (high) local concentration, (low) local substitutability and (weak) local competitive constraints interchangeably.
- 6.284 A hospital operator’s outside option is determined by the extent to which the hospital operator in any local area is able to avoid the loss of the insurer’s policyholders as patients and by its ability to seek patients from other sources, whether insured, self-pay or NHS funded. That is, to the extent that a delisting results in policyholders switching PMI in order to maintain their access to the delisted hospital, and to the extent that any business lost by the hospital operator can be replaced, this will strengthen the hospital operator’s outside option.
- 6.285 While the bargaining outcome depends on the outside options of both PMIs and hospital operators, the focus of our analysis has been on the former. This is because local competitive conditions in the provision of private healthcare are reflected in PMIs’ outside options. We note that the fact that the bargaining outcome depends on the outside options of PMIs is what gives rise to a positive relationship between local hospital concentration and insured prices.
- 6.286 The hospital operators we have investigated own portfolios of hospitals and, with the exception of HCA, these hospitals are spread across many local areas characterized by different degrees of local competition. Also, the negotiated prices are not set at the hospital level but reflect average prices across the hospital operator’s portfolio of hospitals contracted with the PMI. Given this, the existence of a relationship between local concentration and insured prices implies that (a) hospital operators with hospitals in concentrated local areas will achieve higher prices with PMIs than they would

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<sup>394</sup> CC3, paragraph 176.

<sup>395</sup> We use the term buyer power to refer to bargaining power of the buyer which falls short of countervailing buyer power.

<sup>396</sup> We explain in Appendix 6.11, paragraph 64, that if unable to reach an agreement with a hospital operator the ultimate threat available to a PMI is to remove, or threaten to remove, some or all hospitals from its networks, so that policyholders would not be able to use these hospitals under the terms of their insurance policy. This we refer to as a ‘full delisting’.

<sup>397</sup> The strength of an insurer’s outside option will not only reflect local concentration, but is more generally related to its ability to divert policyholders under the terms of the policy away from the delisted hospital.

<sup>398</sup> We note that in local areas where concentration is high, a large PMI may even have a disadvantage as a result of its size, as it may be less able than a smaller PMI to find sufficient substitutable hospitals to which to divert its customer base.



if they had no hospitals in concentrated local areas, and (b) those operators characterized by higher average local concentration across their portfolio of hospitals (ie with hospitals in more concentrated local areas and/or with proportionately more hospitals in concentrated local areas) will achieve higher prices with PMIs than operators with lower average local concentration.

- 6.287 The existence of a relationship between local concentration and insured prices does not imply that other factors might not also influence negotiations and the bargaining outcome between PMIs and hospital operators. Rather, other things being equal, local concentration is expected to be positively correlated with and, in a context of barriers to entry and expansion, causally linked to insured prices as described in paragraph 6.286. We discuss the factors possibly affecting the bargaining outcome and the implications for our empirical analysis in paragraphs 6.363 to 6.368 and 6.370.
- 6.288 Some parties commented on our economic framework for analysing insured prices. BMI argued that an analysis of bargaining power should focus on parties' strategies to force a favourable outcome in negotiations and not which hospitals are dispensable in the medium or longer term. We agree that in analysing the relative bargaining power of parties it is necessary to look at their strategies to strengthen their outside options and thus improve the outcome of the negotiations. HCA also submitted a theoretical model for the bargaining analysis, arguing that the bargaining outcome depended not only on the parties' outside options in the case of a permanent breakdown in negotiations, but also on what HCA termed the parties' 'inside options' in the case of a temporary breakdown in negotiations. We agree that both short-term and long-term factors are relevant and this is considered in our analysis. We use the term 'outside options' to include both short-term and long-term factors.
- 6.289 However, most of the parties' comments were directed at the way in which we assessed the evidence of the PMIs and hospital operators' relative bargaining power rather than the economic framework underlying our analysis.

### *Review of the evidence from internal documents and other evidence*

- 6.290 In this section, we summarize our review of parties' internal documents, responses to questionnaires and submissions in order to understand better the factors the hospital operators and PMIs take into account when negotiating. Our full review of this evidence is set out in Appendix 6.11.

### *Nature of negotiations*

- 6.291 Contracts between a hospital operator and a PMI are typically the product of bilateral negotiations where an agreement is reached over price and the terms on which the parties will trade with each other. There is normally a principle contract that governs the relationship between a hospital and a PMI. In the case of smaller PMIs, this is often a loose annual agreement that is focused on the price of particular services. In the case of the larger PMIs, this is usually a more detailed multi-year contract that along with prices sets a number of detailed conditions. In some cases, this may be augmented by smaller separate agreements covering a new policy or specific services.
- 6.292 Prices are generally agreed nationally across an operator's entire portfolio of hospitals, although in some cases specific additional discounts from the national price may

be agreed between an insurer and a hospital.<sup>399</sup> In addition, rather than negotiating over the price of individual treatments, parties will generally negotiate at renewal over a single percentage increase in prices across all treatments.

- 6.293 Contracts between hospital operators and PMIs do not generally specify a volume of business. The more patients that an insurer can deliver, or indeed withhold, the better the price for the insurer, ie this will increase their bargaining power with the hospital operators. Whilst hospital operators seek the broadest possible recognition for all their facilities, and insurers use this where possible to negotiate the lowest possible price, we found no evidence that the hospital operators included in their contracts a requirement on insurers to recognize all their hospitals.<sup>400</sup>
- 6.294 Volume discounts tended to be negotiated on the basis of an insurer's total patient volumes in any one year across the entirety of the hospital operator's portfolio. Consequently, if an insurer were to delist some of the hospitals belonging to an operator, this could have a significant impact on the prices paid by the insurer at the hospital operators' remaining hospitals due to a reduction in volumes and therefore discounts. Several of the PMIs argued that such a reduction in discounts may disincentivize an insurer from delisting any hospitals belonging to such an operator and discourage them from taking such steps, even in areas where there may be a cheaper provider that they would prefer to encourage patients to use. Hospital operators told us that volume discounts were structured to reflect in the first instance the high fixed costs that hospital operators faced and the fact that insurers did not commit to achieving particular volumes either nationally or at particular hospitals.
- 6.295 All the volume discount schemes we have reviewed are designed to reward the PMI for growing its volume across the whole portfolio of hospitals. We have not found any schemes of the major hospital operators that rewarded a PMI for growing its business at specific sites. By rewarding incremental growth relative to total national volumes in this way, the hospital operator creates an incentive to maximize recognition for a given operator and a disincentive to recognize rival hospitals.

### *Role of local competitive conditions*

- 6.296 On the basis of the considerations set out in paragraphs 6.278 to 6.289, our review of the internal documents and parties' submissions considered whether and to what extent this evidence indicates that the two parties in negotiations take into account local concentration in assessing their bargaining position.
- 6.297 Several insurers confirmed that their negotiating position was driven by the nature of each hospital's portfolio of hospitals, in particular the number, where they were located and the competitive conditions in each local area in which the hospital operator operated.<sup>401</sup> Insurers refer to hospitals for which they have limited alternatives to serve their policyholders as 'must have'. Insurers do not necessarily characterize hospitals in the same way: what may be a 'must-have' hospital for one insurer will not necessarily be regarded as a 'must-have' hospital for another insurer.<sup>402</sup>

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<sup>399</sup> Examples of discounts being granted in return for recognizing new facilities are set out in Appendix 6.11, paragraph 179.

<sup>400</sup> See Appendix 6.11, paragraph 81, where AXA PPP referred to the hospital operators' objective to achieve recognition for as many of their non-solus hospitals as possible. See Appendix 6.11, paragraph 179, for examples where a PMI was able to secure a discount in return for recognition of a new facility.

<sup>401</sup> Parties' submissions on the relevance of local competition to negotiation are set out in Appendix 6.11, paragraphs 11–21.

<sup>402</sup> Our local assessments of hospitals outside central London in Appendix 6.7 provide numerous examples of insurers characterizing a particular hospital differently. In central London, [§].

- 6.298 Most of the private hospital groups, on the other hand, argued that local concentration was not relevant in national negotiations as there was little they could do to take advantage of any local concentration in national negotiations. BMI considered that the delisting of 37 of its hospitals by Bupa in January 2012, including of hospitals identified by the CC as solus hospitals in its provisional findings, demonstrated that Bupa had sufficient alternatives to the delisted hospitals and was capable of diverting patients to alternative facilities.<sup>403</sup> Spire similarly argued that there were reasonable substitutes for all its hospitals and that even if a particular hospital had local market power, [§].<sup>404</sup> HCA argued that there was sufficient spare inpatient capacity in central London alone for any of the largest PMIs to have a viable alternative to HCA's hospitals.<sup>405</sup>
- 6.299 The private hospital groups also argued that, in any event, there were steps that the insurers could take to mitigate local concentration in negotiations including delisting, negotiating improved rates with a competitor on the basis of increased volumes, using network products and other strategies to divert patients away from the operator's hospitals. As a result, they argued, local concentration was not a factor in the national negotiations. However, Nuffield agreed that for some hospital operators local concentration did translate into the national negotiations where the hospital operator owned 'must-have' hospitals. It considered that must-have hospitals were those located in high PMI penetration areas which had a high local market share.<sup>406</sup>
- 6.300 The internal documents of the parties in negotiations show that both parties, in assessing their relative bargaining position, look at the local competitive position of the hospital operator's hospitals. PMIs in assessing their outside options consider the availability and suitability of alternative hospitals in the event of a delisting. This is confirmed by the insurers and Nuffield in their submissions. Whilst the hospital operators argued that local concentration was not relevant, their arguments focused on the fact that they did not consider that they had 'must-have' hospitals or that their outside options were weaker than the insurers'. We have considered in Appendix 6.7 the extent to which the private hospital operators have hospitals which are subject to insufficient local competitive constraints from the viewpoint of the insurers, and all the private hospital groups own such hospitals. As described in Appendix 6.11, paragraphs 22 to 61, the internal documents of the hospital operators clearly show that in preparing for negotiations, the hospital operators review the strength of their portfolio of hospitals, in particular the degree to which they have 'must-have' hospitals for a particular insurer.
- 6.301 We therefore conclude that local concentration is very important in the national negotiations.

### *Bargaining strength*

- 6.302 Our review of the internal documents and of the parties' submissions further considered whether these were informative of the relative bargaining strength of the two parties in negotiations and, in particular, following the discussion in paragraphs 6.278 to 6.289, of the extent of any countervailing buyer power of PMIs.

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<sup>403</sup> BMI response to provisional findings, paragraph 3.2.

<sup>404</sup> Spire response to provisional findings, paragraphs 2.3 & 3.3.

<sup>405</sup> HCA response to provisional findings, paragraph 7.

<sup>406</sup> Nuffield response to provisional findings, paragraphs 3.12 & 3.13.

## Parties' views

- 6.303 The insurers made the following submissions specifically in relation to the relative bargaining power of the parties. AXA PPP submitted that although Spire, Nuffield and Ramsay owned some solus hospitals (or hospitals that were necessary to provide an alternative to one of the other providers), it felt that, in the round, there was a balance in the relative levels of commercial leverage between Spire, these hospital operators and PMIs.<sup>407</sup> In addition, in AXA PPP's view, while PMI buyer power was a positive and mitigating factor up to a point, it was not panacea, most acutely in relation to HCA in London.<sup>408</sup> Its view was that HCA hospitals were essential for its corporate customers in the South-East, meaning that its choice was binary: either AXA PPP had a credible London offer for its corporate customers, which included HCA, or it did not.<sup>409</sup> AXA PPP also stated that the number and proportion of 'solus' hospitals owned by BMI was significant. Although it did not think BMI had sought to leverage its very strong position, it was concerned that it could do in the future.<sup>410</sup> PruHealth stated that, outside London, it had not seen evidence of hospital operators using their local position to influence pricing.
- 6.304 Bupa disagreed with our provisional findings that the total number of hospitals a hospital group owned did not itself impact on the strength of the relative bargaining position of the parties. Bupa argued that several dimensions of 'scale' of a hospital group impact on the hospital group's market power, including the total number of hospitals in a portfolio, the overall financial scale of the hospital group and the number of 'must-have' hospitals in the portfolio.<sup>411</sup> Bupa also argued that its delisting of 37 BMI hospitals in 2011/12 was exceptional and depended critically on the circumstances of that particular negotiation, [X].<sup>412</sup>
- 6.305 HCA considered that PMIs such as Bupa leveraged their bargaining power against hospital operators, including by way of delisting. The consequences of such delisting were much more severe for a hospital operator compared with a PMI. HCA's response criticized our assessment of the evidence in the provisional findings underpinning bargaining, in particular on the relative strength of PMI's outside options compared with those of the hospital operators.<sup>413</sup> HCA argued that the CC should scrutinize the PMI's claims around their outside options if the CC wanted to rely on any such evidence.<sup>414</sup> In HCA's view, the CC appeared to have only relied on the PMI's assertions and figures.<sup>415</sup> HCA submitted that in addition to delisting, insurers had more alternatives than hospital operators and could direct the patient journey in particular through service line tenders, open referrals and guided policies, and that insurers leveraged their resulting buyer power against the hospital operators. HCA also emphasized that the consequences of a delisting were much more severe for a hospital operator compared with a PMI and would result in unsustainable losses on HCA. [X], which gave them a very substantive degree of bargaining power.<sup>416</sup> HCA pointed out that Bupa had publicly stated that it intended to continue to exclude hospital operators that it regarded as too expensive and that AXA PPP already

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<sup>407</sup> [AXA PPP response to annotated issues statement](#), pp3 & 20.

<sup>408</sup> *ibid*, p3.

<sup>409</sup> *ibid*, p4.

<sup>410</sup> Appendix 6.11, paragraph 11(b).

<sup>411</sup> [Bupa response to provisional findings](#), paragraph 4.14.

<sup>412</sup> [Bupa response to annotated issues statement](#), paragraph 2.116.

<sup>413</sup> [HCA response to provisional findings](#), paragraph 7.

<sup>414</sup> For example, in the event of delisting, the ability of PMIs to divert patients to other hospitals or the ability of hospital operators to raise prices in case of loss of volume due to patients being redirected to alternative facilities ([HCA response to provisional findings](#), paragraphs 7.28–7.39).

<sup>415</sup> [HCA response to provisional findings](#), paragraph 7.28.

<sup>416</sup> *ibid*, paragraph 7.10, footnote 22.

delisted HCA from its Pathways insurance network.<sup>417</sup> HCA also noted that our analysis in the provisional findings ignored the effects on negotiating parties of a temporary dispute.<sup>418</sup>

- 6.306 In BMI's view, bargaining power was about using a strategy to force a favourable outcome in negotiations and not about what hospitals were dispensable in the medium or longer term.<sup>419</sup> BMI's submissions focused on Bupa's buyer power in negotiations and contended that Bupa did have countervailing buyer power with regard to BMI.<sup>420</sup> BMI's principal arguments were that (a) bargaining strength should be assessed in terms of the impact of a full or partial delisting by Bupa, and (b) Bupa had far superior outside options compared with BMI in relation to all BMI hospitals and was aware of this. This enabled Bupa to delist 37 BMI hospitals in December 2011 to January 2012. The delisting also demonstrated, BMI submitted, Bupa's very strong outside options as Bupa had alternative hospitals to which it could direct policyholders even in solus and rural areas. Similarly, the delisting of three BMI hospitals in clusters<sup>421</sup> showed that Bupa did not need to use any hospitals in these clusters and was capable of diverting patients away from hospitals. BMI therefore submitted that this undermined the CC's contention that clusters could be leveraged in negotiations with Bupa.<sup>422</sup>
- 6.307 BMI also criticized the evidence the CC relied upon in its analysis of the reputational damage to Bupa of Bupa delisting the 37 BMI hospitals as set out in our provisional findings.<sup>423</sup> BMI considered that through the delisting Bupa had gained a reputation as an uncompromising negotiator and had demonstrated not just the strength of its outside options but its willingness to resort to a delisting. Moreover, BMI claimed that the financial impact on BMI of a delisting was more serious than for Bupa. It added that delisting also led to a loss of consultant loyalty and so-called consultant drag, where the policyholders of other insurers were also diverted away from the delisted hospitals by the consultants.<sup>424</sup>
- 6.308 Spire considered that the evidence showed that (a) PMIs could exert meaningful control over where their policyholders were treated, and that it faced a credible risk that it could lose [X], and (b) while it might be the case that the evidence on national bargaining alone did not as a general matter indicate whether hospital operators had market power or PMIs had buyer power, [X]. Spire in its submissions emphasized that [X]. It also referred to [X].<sup>425</sup> Consequently Spire submitted that the two largest insurers had significant buyer power in negotiations with Spire.<sup>426</sup>
- 6.309 Spire also told us [X].<sup>427</sup> Spire said that if a hospital operator was delisted from a major PMI's network, there would be little action it could take to mitigate the effect and replace lost PMI business.<sup>428</sup> Further, Spire said that the provisional findings

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<sup>417</sup> [HCA response to annotated issues statement](#), paragraph 5.129.

<sup>418</sup> [HCA response to provisional findings](#), paragraph 7.

<sup>419</sup> [BMI response to provisional findings](#), paragraph 4.33.

<sup>420</sup> *ibid*, paragraph 1.2.

<sup>421</sup> 'Clusters' were used in our Remedies Notice to identify areas where an operator had more than one facility and where at least one facility was subject to insufficient competitive constraints. [X]

<sup>422</sup> [BMI response to provisional findings](#), paragraph 3.3.

<sup>423</sup> In BMI's view, receiving complaints from [X] customers which represented [X] per cent of its policyholders and complaints from corporate clients stating they were very dissatisfied with the delisting was no compelling evidence of quantifiable damage of any kind (see [BMI response to provisional findings](#), paragraphs 3.38 & 3.39).

<sup>424</sup> *ibid*, paragraph 4.22.

<sup>425</sup> Appendix 6.11, paragraph 254.

<sup>426</sup> Appendix 6.11, paragraph 77.

<sup>427</sup> [Spire response to annotated issues statement](#), paragraph 4.9.

<sup>428</sup> *ibid*, paragraph 4.11. [HCA response to issues statement](#), paragraphs 10.54–10.63.

themselves recognized that the consultant drag effect of delisting would enhance its impact on a hospital operator and that the evidence supported this. Moreover, [REDACTED].<sup>429</sup>

### *Our assessment*

- 6.310 We are only aware of one example in the UK of a PMI removing a group of hospitals from all of its networks as a result of failing to reach an agreement over a revised contract (ie a full delisting). Appendix 6.11, paragraphs 83 to 112, describe in detail the events surrounding Bupa's delisting of 37 BMI hospitals in December 2011 to January 2012 (the BMI–Bupa delisting).
- 6.311 The ability of an insurer to delist will depend upon:
- (a) the availability and suitability of alternative hospitals for each hospital which the PMI may consider delisting in the event of a dispute;
  - (b) the cost of sending patients to these alternative hospitals, taking into account the terms that would apply or could be agreed;
  - (c) any anticipated increase in price imposed by the hospital operator that faces having some of its hospitals delisted at any hospitals retained on the network;
  - (d) any impact on sales (new business and renewals) due to reputational damage from negative publicity and a perception that the insurer is no longer able to provide access to key hospital facilities; and
  - (e) the financial strength or weakness of a hospital operator and a PMI to withstand a delisting.
- 6.312 We are of the view that Bupa's conduct in the BMI dispute appeared intended to inflict substantial and rapid pressure on BMI, in order to achieve a satisfactory re-negotiation before suffering too much reputational damage with its policyholders and potential new customers. As such, this delisting does not indicate that all of the BMI hospitals that were delisted were dispensable to Bupa or that BMI has no market power as a result. In order to maximize the effect of Bupa's actions in this example, including the reputational effect with the hospital operators, it would be beneficial to Bupa to delist some BMI hospitals with market power. However, although Bupa doubtless felt that it was a favourable moment to delist BMI, we are not convinced that the circumstances were unique.
- 6.313 On the basis of the evidence we have reviewed, it seems that in the case of a PMI the impact of a threat to delist is likely to be enhanced by the greater number of patients (and revenue) it can switch away from a hospital operator, as this would mean that more volume is potentially at risk at any hospitals that were to be delisted. In the case of a delisting by the largest PMIs, the risk that consultants may choose to move their practice to a different site also appears to be real.
- 6.314 However, the more hospitals that a hospital operator owns in areas where there are limited competitive alternatives, and where there were a significant number of PMI customers, the stronger its bargaining position will be.
- 6.315 As noted above, BMI and HCA argued that the CC's bargaining assessment in the provisional findings erroneously centred on a permanent breakdown in negotiations.

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<sup>429</sup> See Appendix 6.11, paragraph 18.

We agree that short-run and long-run factors matter and our analysis takes into account both short- and long-run factors. Local concentration is relevant to the effects of temporary delistings and to the effects of permanent delistings since in both cases PMIs will consider the existence of alternative providers and their ability to divert policyholders to such providers.

- 6.316 We agree that hospital operators appear most unlikely to be able to replace any lost business rapidly and would be severely impacted by a major delisting. The most immediate effect would be loss of revenue which would be significant in the case of a major delisting and/or a delisting by a major insurer. The potential loss of consultants, who will normally wish to continue to be able to treat the PMI's policyholders, is, we agree, also a major issue. However, PMIs will also be severely impacted by a major delisting. They would incur costs of sending patients to alternative hospitals. They are likely to have to pay higher prices to the delisted hospital operator due to reduced discounts. They could lose future sales due to reputational damage.<sup>430</sup>
- 6.317 We do not agree with HCA that the CC could rely on PMIs' assertions and figures in the assessment of PMIs' outside options without the CC scrutinizing those figures itself. The documents we relied upon in our assessment are contemporaneous of the negotiations and are, therefore, informative of the PMIs' 'state of mind' at the relevant time, in particular in relation to how PMIs view the impact of delisting on both parties to the negotiations. It is not relevant whether the PMIs' internal estimates around, for example, the financial losses or the percentage of patients which a PMI could divert to alternative hospitals are accurate or not. Furthermore, BMI<sup>431</sup> and Bupa's own internal estimates and responses to the provisional findings demonstrate that both parties suffered damage as a result of the delisting.<sup>432</sup> It will therefore be in the interests of both parties to reach an agreement as they are mutually dependent on each other. This mutual dependence will lead to both parties extracting a positive share of the bargaining surplus.
- 6.318 We noted that AXA PPP considered that negotiations were broadly balanced between Spire, Nuffield, Ramsay and PMIs.<sup>433</sup> PruHealth also stated that, outside London, it had not seen evidence of hospital operators using their local position to influence pricing. Simplyhealth argued that any countervailing buyer power was limited to the largest PMIs and was not reflective of the entire PMI market.<sup>434</sup> In addition, in reviewing the internal documents, we noted that [redacted].<sup>435</sup> An HCA planning document from HCA's negotiations with Bupa in 2009 [redacted].<sup>436</sup>
- 6.319 Contrary to BMI's view in particular, we do not consider that the fact that the buyer is of the view that the parties' relative bargaining positions are broadly balanced indicates that the insurer has countervailing buyer power. Rather it is consistent with our view that both parties to the negotiations are extracting a share of the surplus and therefore the supplier retains some market power in the negotiations. This damage to both parties is also likely to occur in any future sizeable delisting episodes.
- 6.320 Similarly, we do not agree with BMI and other hospital operators that even if the hospital operator is likely to suffer disproportionate damage compared with the

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<sup>430</sup> Appendix 6.11, paragraphs 24–40, set out evidence where PMIs evaluate the anticipated cost to themselves of removing a hospital operator from their network.

<sup>431</sup> See in particular Appendix 6.11, paragraph 112, where BMI recognized that the delisting episode was damaging to both itself and Bupa.

<sup>432</sup> As discussed above, the fact that BMI suffered as a result of the delisting is evidence of its ability to extract a substantial share of the bargaining surplus.

<sup>433</sup> [AXA PPP response to annotated issues statement](#), pp 3 & 20.

<sup>434</sup> [Simplyhealth response to annotated issues statement](#), p1.

<sup>435</sup> Appendix 6.11, paragraphs 34 & 35.

<sup>436</sup> Appendix 6.11, paragraph 53.



insurer this means that the insurer has countervailing buyer power. On the contrary, irrespective of the precise magnitude of damage, because both the hospital operator and the PMI would suffer damage as a result of any delisting episode, even though this might not be equally distributed between them, they are both able to extract a share of the bargaining surplus if an agreement is ultimately reached which was the case in the BMI–Bupa delisting.

- 6.321 Several hospital operators also argued that the recent Bupa delisting of BMI significantly enhanced Bupa’s reputation and the credibility of any threat to delist.<sup>437</sup> BMI argued that this extended to other PMIs, noting that if Bupa could redirect a very high proportion of BMI’s volume, so could other PMIs.<sup>438</sup>
- 6.322 We note that the reputational damage is difficult to ascertain and in particular what impact it may have on future negotiations not only with BMI but also other operators. It is also necessary to counterbalance any possible positive impact the BMI–Bupa delisting had on Bupa’s reputation vis-à-vis the hospital operators, with any likely negative repercussions on Bupa’s reputation with its customers and competitors. Besides the ‘bad’ publicity and complaints from policyholders and corporate clients, Bupa [redacted].<sup>439</sup>
- 6.323 Bupa’s largest competitor, AXA PPP, [redacted] believed that the dispute with BMI was one factor which contributed to Bupa’s loss of market share.<sup>440</sup> This possibility is also not excluded by BMI’s internal view at the time.<sup>441</sup> Therefore, we are of the view that any positive impact the delisting episode might have had on Bupa’s reputation by strengthening its image as a strong negotiator has to be mitigated by the negative perception of the market that Bupa lost market share.
- 6.324 The strength of an insurer’s outside option to delist is linked to the insurer’s ability to divert patients away from the delisted hospital or the operator in the case of a full delisting. Moreover, the ability to direct policyholders to or from particular hospitals is a key issue in negotiations for volume-related discounts, as discussed above. The PMIs have in recent years adopted a number of strategies to try to improve their ability to divert patients from one facility to another. As explained in Appendix 6.11, paragraphs 125 to 174, PMIs offer policies under which policyholders have access to a smaller number of hospitals in return for other benefits—usually lower premiums (restrictive network policies). Similarly PMIs have also introduced specialist network policies limited to particular treatments or diagnostics. Such policies in principle enable PMIs to delist certain hospitals or indeed operators whilst reducing the damage of a delisting from a general network. Specialist network policies also enable PMIs to operate individual tenders to try to secure better prices.
- 6.325 However, even under such restrictive network policies and specialist network policies, PMIs still need to be able to offer an acceptable choice of hospitals to ensure sufficient take-up by policyholders. Given the current levels of take-up on restricted network policies (see Appendix 6.11, paragraph 146), the fact that many corporate customers in particular require policies to provide broad coverage<sup>442</sup> and that there are a limited number of treatments for specialist network policies, we do not consider that such strategies materially improve the PMIs’ outside options.

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<sup>437</sup> [Spire response to annotated issues statement](#), paragraph 4.35; [HCA response to annotated issues statement](#), paragraph 5.49.

<sup>438</sup> [BMI response to annotated issues statement](#), paragraph 8.13.

<sup>439</sup> Appendix 6.11, paragraphs 90–98.

<sup>440</sup> Appendix 6.11, paragraph 96.

<sup>441</sup> Appendix 6.11, paragraph 97.

<sup>442</sup> On the importance of offering policies with sufficient coverage, see, for example, Appendix 6.11, paragraphs 11(c), 118, 141, & 158.



- 6.326 Where hospital operators purchase or build a new facility, they will have to seek recognition from each PMI in order to have the new hospital added to the PMIs' networks. In some cases, contracts between PMIs and hospital operators specify how price and/or recognition will apply in the event of a hospital operator making an acquisition, whereas in others the terms of any recognition will be negotiated bilaterally in the same way as in the main national negotiations.
- 6.327 Where recognition is negotiated bilaterally, several hospital operators made representations about PMIs' strong negotiating position where a hospital operator asked a PMI to recognize a new facility that was not previously included on the hospital network.<sup>443</sup> HCA argued that the financial harm of, for example, a lack of recognition of a facility by Bupa was that the viability of that facility was threatened.<sup>444</sup>
- 6.328 Insurer recognition is considered in some detail in paragraphs 6.108 to 6.122 above on barriers to entry and expansion, where we conclude that insurer recognition is not a barrier to entry or expansion. As in the national negotiations, the relative bargaining power of the parties in negotiations for recognition will depend on the parties' outside options. In particular, if the new facility is located in an area where the insurer has alternative providers, the insurer's outside option—ie not to recognize (as opposed to delist in the context of national negotiations)—will be strong and therefore the insurer will achieve a lower price.
- 6.329 The introduction of policies under which insurers require policyholders to obtain an open referral from their referring clinician (open referral policies) is considered in detail in paragraphs 7.82 to 7.92. We have seen no evidence that PMIs are able to divert significant numbers of patients from or to specific operators' hospitals as a result of these measures. Thus whilst the increased role of insurers in directing patients to particular facilities may have the potential to strengthen the insurers' negotiating power, there is little evidence to suggest that to date it has done so to a significant extent. As noted previously, the scope for these strategies to strengthen the insurers' bargaining strength is dependent upon the availability of alternative facilities and as such does not materially alter the insurers' outside options (as opposed to limiting the damage caused by a delisting).

### *Conclusions on the review of the submissions and internal documentary evidence*

- 6.330 We found that the competitive position of hospitals at the local level is an important factor that both PMIs and hospital operators take into consideration in their negotiations over insured prices. In particular, we found that, in assessing their bargaining position, PMIs consider the availability and suitability of alternative hospitals for each hospital which they may consider delisting in the event of a dispute. This suggests that the substitutability between local hospitals matters in negotiations and is consistent with the existence of a relationship between local concentration and insured prices.
- 6.331 We found that the PMIs and hospital groups are dependent upon each other and it does not appear that either side anticipates it would survive without substantial damage in the event of a sizeable delisting. This suggests that both these parties to the negotiations have some degree of bargaining power, also depending on the strength of their outside options. This will vary from hospital operator to hospital operator and from insurer to insurer. Our analysis of the internal documents and parties' submissions relating to the conduct of national negotiations does not enable

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<sup>443</sup> Spire response to annotated issues statement, p32.

<sup>444</sup> HCA response to provisional findings, paragraph 7.13.

us to determine how their respective bargaining strength affects the bargaining outcome.

- 6.332 However, we observed that, as a result of the 2011/12 Bupa–BMI delisting, both parties appear to have suffered substantial damage. This suggests that both parties managed to extract a share of the bargaining surplus when an agreement was reached.

### ***Empirical analysis of insured prices***

- 6.333 We refer to paragraphs 6.278 to 6.289 setting out our economic framework for analysing the negotiations between hospital operators and PMIs. Our empirical analysis of insured prices focused largely on six hospital operators (HCA, TLC, BMI, Spire, Nuffield and Ramsay) and several PMIs (Bupa, AXA PPP, Aviva, Standard Life, Simplyhealth, Cigna, PruHealth, WPA, Exeter Family Friendly, and Bupa International).
- 6.334 The aim of our empirical analysis of insured prices was twofold. First, we wanted to compare the prices charged to PMIs across different hospital operators as well as the prices paid to hospital operators across different PMIs. This was a complex task due to the differences between hospital operators in the treatments that they offer and the mix of patients that they treat. Second, as noted in paragraph 6.283, we wanted to assess whether and how the prices charged by hospital operators to PMIs are related to the substitutability of the operators' hospitals in local areas. Our ability to analyse this second issue, however, was significantly influenced by the prices negotiated between hospital operators and PMIs not generally being set for individual hospitals (ie at the local level), but rather a single average price being set for all hospitals in an operator's portfolio.
- 6.335 This section is organized as follows. First, we outline our methodology for measuring insured prices and assessing their relationship with local substitutability. Second, we discuss the main results of our empirical analysis comparing insured prices between hospital operators; for the reasons explained below in paragraph 6.338, these results are presented separately for central London hospital operators (HCA and TLC) and the four main hospital operators active in the rest of the UK (BMI, Nuffield, Ramsay and Spire). Third, we present additional results that compare insured prices between PMIs and relative to self-pay patients. Finally, we provide a summary of the main comments made by the parties in response to this analysis. Appendix 6.12 sets out the full details of our analysis.

### ***Methodology***

- 6.336 We first explain the approach we took to construct a measure of insured prices that would be comparable between operators. To this end, we constructed a measure that we refer to as a 'price index'. The price index is based on a common basket of treatments offered by the different hospital operators to each PMI. It aggregates into a single number the prices charged by each hospital operator to a PMI for patients treated at the hospitals owned by the operator.<sup>445,446</sup> As explained below, our

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<sup>445</sup> These calculations are based on underlying data that records the 'episode price' charged for each patient treated. The definition of an episode price is the price for hospital services excluding consultant fees and ancillary services (eg phone calls, food, newspapers). The data was sourced from Healthcode, an intermediary between hospital operators and PMIs.

<sup>446</sup> We include the following PMIs in our analysis (in descending order of admissions in the Healthcode data): Bupa, AXA PPP, Aviva, Standard Life Healthcare, Simplyhealth, Cigna, PruHealth, WPA, Exeter Family Friendly and Bupa International. These are all of the PMIs that are included in the Healthcode data and account for the large majority of providers in the market. Several

methodology controls for a number of potential differences between hospital operators. We considered the price index to be the most informative basis on which to compare insured prices.<sup>447</sup> Using a similar methodology that is explained in Appendix 6.12, we also constructed a measure of insured prices that allowed for comparisons between prices paid by PMIs and self-pay patients.

- 6.337 We examined the price index for each hospital operator on average across PMIs (referred to as the 'average price index', eg BMI's average insured price for its insured patients) and separately for each PMI ('insurer-specific price index', eg BMI's average insured price for Bupa's insured patients).<sup>448, 449, 450</sup>
- 6.338 We have split our analysis between central London and the rest of the UK. This allowed for the analysis to control for potential differences, such as treatment/patient mix and marginal costs, between the operators active in central London and those active across the rest of the UK. For central London, our analysis focuses on the comparison between HCA and TLC on the basis that they are the largest two operators in terms of size and we considered them to be the closest competitors to each other. Given that HCA and TLC are almost exclusively based in central London, insured prices in this case are the same as local prices.<sup>451</sup> For the rest of the UK, our analysis focuses on the comparison between the four larger hospital operators, BMI, Spire, Nuffield and Ramsay, which own portfolios of hospitals spread across a number of local areas in the UK.
- 6.339 Our analysis focused on inpatient and day-case treatments.<sup>452</sup> Inpatient and day-case treatments accounted for on average 75 per cent of the hospital operators' revenue from insured patients in 2011.<sup>453</sup> The revenue proportion of the inpatient and day-case treatments included in the common baskets of treatments that we analysed varied depending on the particular price comparison (eg by PMI, hospital operator and year).<sup>454</sup>
- 6.340 The price index methodology controls for differences between hospital operators in the mix of treatments that they offer and the mix of patients that they treat. Treatment mix is accounted for by examining a common basket of treatments across hospital operators for each PMI. Patient mix is accounted for by comparing the prices hospital

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of these PMIs merged in more recent years (eg Pruhealth and Standard Life Healthcare); we have kept these PMIs separate in the analysis as we understand that in several instances separate contracts remained in place for some time after the merger.

<sup>447</sup> HCA questioned why we had used the invoice data for our analysis, when we would have been in a position to analyse the price schedules negotiated between PMIs and hospital operators. We used the invoice data as we did not consider analysing the price schedules to be a practical approach. The price schedules and contracts for each PMI and each operator were generally not readily available in a format that was easily comparable across all treatments throughout the period. We noted that PMIs also use the out-turn invoice data to compare the prices they pay between hospital operators rather than the contracts that they have in place with hospital operators.

<sup>448</sup> The average price index result is produced by taking a weighted average of the insurer-specific price index results.

<sup>449</sup> There was significantly more data available for certain PMIs (eg Bupa and AXA PPP) compared with the other PMIs, as explained in Appendix 6.12.

<sup>450</sup> As we explain later, consistency between these two sets of results (on average across PMIs and for individual PMIs) provided us with greater confidence that our results are robust.

<sup>451</sup> The only exception in terms of inpatient facilities is that HCA also operates a PPU in Manchester and a PPU in Greater London. These facilities accounted for less than 1 per cent of the price data that we analysed and are therefore unlikely to have a material effect on our results.

<sup>452</sup> We were not able to include outpatient treatments in our analysis because the data for these treatments could not be systematically classified in the same way as inpatient and day-case treatments. Inpatient and day-case treatments are classified according to a unique CCSD code. This coding system does not cover outpatient treatments and we were not able to link outpatient treatments (eg physiotherapy following an operation) to the associated inpatient treatments (eg hip replacement). We explain later that we do not expect the omission of outpatient treatments to influence our conclusions materially.

<sup>453</sup> This is based on aggregate revenues for BMI, HCA, Nuffield, Ramsay, Spire and TLC.

<sup>454</sup> For example, in 2011 the central London analysis used between [X] and [X] per cent of inpatient and day-case revenue for AXA PPP and Bupa and between [X] and [X] per cent for the smaller PMIs, while for the analysis of the rest of the UK, the comparable figures are between [X] and [X] per cent for AXA PPP and Bupa and between [X] and [X] per cent for smaller PMIs. The figures for other years are broadly comparable.

operators would charge for treating the same ‘representative patient’.<sup>455</sup> The price index also accounts for potential differences between central London operators and those operators active in the rest of the UK by conducting the analysis separately for these two geographic areas. These potential differences may be in terms of marginal costs and any other factors, such as product offering, complexity of case mix or quality of service.<sup>456</sup> While we recognized that such differences may also exist between specific local areas outside central London, we did not consider that these differences would be material when considered on average across the entire portfolio of each operator’s hospitals (see paragraphs 6.364 to 6.366).

- 6.341 We tested the robustness of our price index results by testing whether any differences in price were statistically significant and by conducting a sensitivity analysis. The sensitivity analysis considered a number of modifications to our methodology and/or the data included in our analysis. In general, we found that the price differences we estimated were, in the large majority of cases, statistically significant and that the larger price differences we estimated were robust to the sensitivity analysis. The details of these tests are explained in Appendix 6.12, and we comment on specific results below.
- 6.342 We now explain our approach to comparing insured prices with local substitutability. We used the price index averaged across PMIs as our price measure in these comparisons.<sup>457</sup> We compared this price measure with measures of local concentration, which we used as a proxy for local substitutability. For central London, we used our shares-of-supply and capacity estimates which are specific to this local area (see paragraphs 6.205 and 6.210). For the rest of the UK, since each operator is present in many different and overlapping local areas, measuring local concentration was more involved and we used local concentration measures that are averaged over the local areas. We considered a number of alternative definitions for the average measures of local concentration and found that the ranking between hospital operators is generally preserved (Ramsay has the portfolio of hospitals that on average faces strongest competitive constraints, followed by Nuffield and Spire although the ranking between these two operators varies according to the measure, and BMI has the portfolio of hospitals that on average faces the weakest competitive constraints), which meant that our comparisons between price and local concentration were robust to the choice of the concentration measure (see Appendix 6.12).<sup>458</sup> For simplicity, the results presented here are based on one concentration measure only, the proportion of hospitals of concern in an operator’s portfolio. The advantages of this measure, which is based on our local assessments of individual hospitals, are that it is easy to interpret and incorporates all the information we had available for the analysis of local competitive constraints (see paragraphs 6.161 to 6.198 for an explanation). A disadvantage of this measure is that it only provides a binary categorization of hospitals (insufficiently or sufficiently constrained) and does not reflect more incremental degrees of competitive constraints faced by each hospital.
- 6.343 Our comparison between insured prices and local concentration has a number of inherent limitations. These stem from the fact that insured prices are not set or observed at the level of the individual local hospital. We noted the following:

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<sup>455</sup> The representative patient is defined, separately for each treatment, as having median patient characteristics (age, gender, length of stay). The price of treating such a patient is predicted on a treatment-by-treatment basis using regression analysis.

<sup>456</sup> By case mix, we refer here to further unobservable differences that may not be accounted for by our approach to controlling for patient mix.

<sup>457</sup> In general, we were interested in outcomes for the average consumer regardless of their PMI provider.

<sup>458</sup> The local concentration measures we considered are based on LOCI and the outcome of our detailed local assessments (ie whether a hospital is a competition concern or not). We considered simple and weighted averages, with weights based on the number of insured patient admissions.

- (a) We did not have many price observations, only one per operator per year (ie two per year for central London, four per year for the rest of the UK). This precluded a statistical analysis of the type we conducted for self-pay patients (ie PCA).
- (b) Our analysis does not systematically control for certain factors. This arises largely as a result of the number of price observations being small. We discuss this in more detail below in response to the parties' comments.
- (c) In relation to our analysis outside central London, the fact that insured prices are averaged over many local areas, where the competitive conditions vary, will reduce the average price differences between operators and, to a degree, dilute any observed relationship between these prices and local concentration.<sup>459</sup> All else equal, it will therefore be harder to identify any relationship between insured prices and local concentration for the rest of the UK compared with central London—the difference is that for central London we are able to observe insured prices for a single local area rather than as an average across areas.

6.344 Notwithstanding these limitations, we considered that the analysis is sufficiently reliable to contribute to the evidence regarding the role of local concentration in determining insured prices (see paragraphs 6.381 to 6.383). The limitations noted above, however, do highlight the need to consider this evidence in the context of the other evidence (see paragraphs 6.377 and 6.378).

### *Results for HCA and TLC*

6.345 Figure 6.2 below shows the average price index for HCA and TLC for each year over the period 2007 to 2011.

FIGURE 6.2

#### **Average price index: HCA and TLC, 2007 to 2011**

[X]

Source: CC analysis.

Note: Prices are nominal (ie have not been adjusted for inflation).

6.346 As shown in Figure 6.2, we found that HCA charged higher prices than TLC, on average across PMIs, in each of the years 2007 to 2011. HCA was more expensive than TLC by [X] per cent in 2007 and by [X] per cent in 2011. On average, over the period 2007 to 2011, HCA was more expensive than TLC by [X] per cent.<sup>460</sup>

6.347 We also found that the results of the insurer-specific price index are consistent with the average price index results. For the two largest PMIs in central London [X].<sup>461, 462</sup>

<sup>459</sup> An example demonstrates this. Consider the case when there are only two types of equally-sized hospitals, A and B, and type A faces fewer competitive constraints than type B such that the insured prices are £1,000 and £900 at each type of hospital respectively. Now consider two hospital operators, X and Y, each owning 50 hospitals. Operator X owns 40 hospitals of type A and 10 of type B, while operator Y owns 20 hospitals of type A and 30 of type B. In this example, there is a relationship between insured prices and the local substitutability of the hospitals. Operator X has a portfolio of hospitals that are less substitutable at the local level and it charges higher insured prices. When insured prices are measured on average across each operator's portfolio, Operator X will have an average insured price of £980 ( $40/50 \times £1,000 + 10/50 \times £900$ ) while operator B will have an average insured price of £940 ( $20/50 \times £1,000 + 30/50 \times £900$ ). Thus in this example, while the less substitutable hospitals (type A) attract a price that is £100 (or around 10 per cent) higher than the more substitutable hospitals (type B), when comparing the average prices of two operators the difference appears more muted at £40 (or around 4 per cent).

<sup>460</sup> The sensitivity analysis confirmed that the price ranking between HCA and TLC is robust to methodological changes, although price differences may be subject to small changes.

<sup>461</sup> The exceptions to this are [X] in 2008 (TLC and HCA [X]) and [X] in 2007 (TLC is [X] higher than HCA).

These results are consistent with what the PMIs told us (ie HCA was more expensive than TLC).

- 6.348 In terms of local concentration in central London, we found that HCA had significantly higher shares of supply and of capacity than TLC (see paragraphs 6.205 to 6.210). In 2011, for instance, HCA had a share of admissions of [40–50] per cent and a share of overnight bed capacity of [40–50] per cent. This compared to TLC which had shares of [10–15] per cent and [10–15] per cent for the two measures respectively.
- 6.349 For central London, we therefore noted that HCA charges significantly higher prices than TLC in each year over the period 2007 to 2011 (on average across PMIs and for the majority of PMIs individually) and HCA has significantly higher shares of supply and capacity than TLC in 2011. This comparison shows that, for HCA and TLC, insured price outcomes and local concentration (as measured by their respective shares of supply and capacity) are positively associated.<sup>463</sup>

### *Results for BMI, Nuffield, Ramsay and Spire*

- 6.350 Figure 6.3 shows the average price index for BMI, Nuffield, Ramsay and Spire for each year over the period 2007 to 2011.

FIGURE 6.3

### **Average price index: BMI, Nuffield, Ramsay and Spire, 2007 to 2011**

[X]

Source: CC analysis.

Note: Prices are nominal (ie have not been adjusted for inflation).

- 6.351 As shown in Figure 6.3, we found that for all years the prices charged by BMI, Nuffield and Spire, on average across PMIs, are higher than the prices charged by Ramsay. We noted that the prices charged by BMI, Nuffield and Spire are broadly similar, with the differences ranging from around [X] per cent in 2007 (BMI higher than Nuffield) to around [X] per cent in 2011 (Spire higher than Nuffield). We also noted that the difference in the average price charged by the three higher price operators (BMI, Nuffield and Spire) and Ramsay was around [X] per cent in 2007 and was then relatively stable at between [X] and [X] per cent over the period 2008 to 2011.<sup>464</sup>
- 6.352 The results of the insurer-specific price index for BMI, Nuffield, Ramsay and Spire, however, indicated some inconsistencies with the average price index results. Concerning the larger PMIs, we found that: [X].<sup>465</sup> We compared these results with the results of the PMIs' own internal analysis, and this also highlighted some

<sup>462</sup> The price differences between HCA and TLC for the five largest PMIs were statistically significant in the majority of years. The exceptions to this are [X]. We did not test the statistical significance for the very small PMIs.

<sup>463</sup> We expect that this positive association has been broadly stable over the period 2007 to 2011 as we are not aware of factors that would have substantially affected the shares of supply over this period, and there is a price difference between HCA and TLC in each year over the period 2007 to 2011.

<sup>464</sup> The sensitivity analysis confirmed that the prices charged by BMI, Nuffield and Spire are broadly similar and typically higher than the prices charged by Ramsay. The exceptions to this are the results of two sensitivities that showed, for 2007 only, similar prices for Nuffield, Ramsay and Spire. The sensitivity analysis also indicated that the price differences and rankings between BMI, Nuffield and Spire depend on the details of the methodology.

<sup>465</sup> The price differences between the pair-wise combinations of BMI, Nuffield and Spire (eg BMI vs Spire) for the five largest PMIs were statistically significant in the majority of years. The exception to this is BMI-Spire for [X] in 2009. We did not test the price differences relative to Ramsay; however, the larger price differences between Ramsay and other operators strongly suggest that all price differences would be statistically significant. We did not test the statistical significance for the very small PMIs.

inconsistencies.<sup>466</sup> In particular, internal analysis by [X], and internal analysis by [X].

- 6.353 Figure 6.4 shows a graphical comparison of the average price index results for 2011 with the proportion of hospitals of concern in an operator's portfolio for BMI, Nuffield, Ramsay and Spire.<sup>467</sup>

FIGURE 6.4

**Average price index (2011) vs proportion of hospitals of concern:  
BMI, Nuffield, Ramsay and Spire**

[X]

Source: CC analysis.

- 6.354 Figure 6.4 indicates a weak positive association between average insured prices and the proportion of hospitals of concern in each operator's portfolio.<sup>468,469</sup> Compared with our expectations (see paragraphs 6.278 to 6.289), the above comparison shows some inconsistencies. Ramsay is the lowest-price operator on average across PMIs and is also characterized by the least concentrated portfolio of hospitals relative to the other three operators. BMI, Nuffield and Spire are the higher-price operators and are also characterized by more concentrated portfolios of hospitals relative to Ramsay. However, we note that while Nuffield and Spire are close to each other in terms of the proportion of hospitals of concern and also in terms of prices, their prices are also similar to BMI which has a higher proportion of hospitals of concern. The results of a comparison between insured prices and local concentration were similar when we used other average measures of local concentration, each comparison showing a similar inconsistency to that described above (see Appendix 6.12, Figure 8).

*Results comparing PMIs with self-pay patients*

- 6.355 The preceding results compared the prices charged to PMIs between different hospital operators. In this section we discuss additional results, based on the same price index methodology, that compare, for each hospital operator, the prices charged to PMIs and self-pay patients.<sup>470</sup> This analysis has been undertaken for BMI, HCA, Nuffield, Ramsay and Spire.<sup>471</sup> We explain the methodology in detail in Appendix 6.12 (see paragraphs 22 to 24).
- 6.356 The price index results for HCA, over the period 2007 to 2011, showed that [X] paid prices that were similar to, and in a small number of cases up to [X] per cent lower

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<sup>466</sup> We noted that there are methodological differences between our analysis and the PMIs' analysis. For example, our analysis controls for patient mix and their analysis typically does not.

<sup>467</sup> In terms of the proportion of hospitals of concern in the portfolio, we found that BMI has 66 per cent, followed by Nuffield at 35 per cent, Spire at 33 per cent and Ramsay at 27 per cent.

<sup>468</sup> It is weak in the sense that there is not a positive correlation if only Nuffield, Spire and BMI are considered.

<sup>469</sup> We expect that this weak positive association has been broadly stable over the period 2007 to 2011 as we are not aware of factors that would have substantially affected the proportion of hospitals of concern over time, and there is a price difference between the three higher-priced operators (BMI, Nuffield and Spire) and Ramsay in each year over the period 2007 to 2011.

<sup>470</sup> The results for the smaller PMIs were based on small data samples. We therefore analysed data only for the three largest PMIs after Bupa and AXA PPP, and analysed these smaller PMIs as part of our sensitivity analysis. For central London, these PMIs were Cigna, PruHealth and Standard Life Healthcare. For the rest of the UK, these PMIs were Aviva, Simplyhealth and Standard Life Healthcare.

<sup>471</sup> TLC was not included in the comparison between PMI and self-pay price outcomes as we did not obtain self-pay data for TLC.

than, the prices paid by self-pay patients.<sup>472</sup> [X] paid prices to HCA that were around [X] per cent higher than the prices paid to HCA by self-pay patients.<sup>473</sup> [X] also paid prices to HCA that were typically higher than the prices paid to HCA by self-pay patients.<sup>474</sup>

6.357 The results for BMI, Spire, Nuffield and Ramsay showed that [X] typically paid lower prices than self-pay patients to each hospital operator. Over the period 2007 to 2011, [X] paid prices that were on average between [X] and [X] per cent lower than the prices paid by self-pay patients at the hospitals belonging to each of the four national hospital operators.<sup>475</sup> Similarly, [X] paid prices that were on average between [X] and [X] per cent [X] than the prices paid by self-pay patients.<sup>476,477</sup> [X] paid prices that tended to be similar to or slightly higher than self-pay prices over the period 2007 to 2011.<sup>478,479</sup> These results were broadly similar for BMI, Nuffield, Ramsay and Spire.

### *Comments made by the parties*

6.358 During the course of this inquiry we have consulted with the hospital operators and PMIs on the empirical analysis discussed above. In response to their comments we made changes and improvements on earlier versions of this analysis.<sup>480</sup> Additional arguments raised by the parties were as follows:

- (a) The price index did not include outpatient treatments, and since prices were negotiated across a bundle of outpatient, inpatient and day-case treatments if the insured price analysis was to be used to understand the relative bargaining position of hospital operators and the PMIs then the basket of treatments analysed needed to be representative of all expenditure with the hospital operators.
- (b) The price index analysis did not include treatments that were sufficiently representative of each hospital operator's spend with each PMI and the number of treatments in the baskets for certain PMIs was too small to allow for a robust analysis.
- (c) The price index analysis relied on data that may not be comparable across hospital operators due to, for example, different ways of recording pre-assessment and post-operative care (either in the price for certain treatments or separately under outpatient care) or the way in which hospital operators billed PMIs when the same procedure was performed more than once during an episode.

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<sup>472</sup> [X] appeared to pay less than self-pay patients to HCA in 2011 ([X] per cent lower), in one sensitivity for all years ([X] per cent on average across years) and in another sensitivity for three years ([X] per cent on average across years).

<sup>473</sup> The price differences between [X] and self-pay patients for HCA were statistically significant only in 2010 and 2011. The price differences between [X] and self-pay patients for HCA were statistically significant in all years.

<sup>474</sup> The price differences between [X] that we analysed and self-pay patients for HCA were on average [X] per cent. The price differences were statistically significant in the majority of cases.

<sup>475</sup> The price differences between [X] and self-pay patients for the four hospital operators were statistically significant in all years.

<sup>476</sup> The prices paid by [X] to [X] were higher than those paid by self-pay patients.

<sup>477</sup> The price differences between [X] and self-pay patients for the four hospital operators were statistically significant in all years.

<sup>478</sup> The price differences between [X] that we analysed and self-pay patients for the four national operators were on average [X] per cent. The price differences were statistically significant in the majority of cases.

<sup>479</sup> The exceptions to this were [X], which achieve a small discount relative to self-pay for some operators in certain years.

<sup>480</sup> For example, the initial version of our price index methodology did not control for patient mix. We have since adjusted the methodology to account for patient mix. We also used a simpler measure of price in our earlier analyses (average revenue per admission). We have since dropped this measure as it does not control for the mix of treatments or patients.



- (d) The price index did not sufficiently control for differences in quality between hospital operators, or other characteristics of hospital operators that affected their costs, such as their status as a charity.
- (e) The price index did not account for 'retroactive' rebates, which would have the effect of lowering the effective price to a PMI when these rebates were paid (usually at the end of the year).
- (f) The comparison between insured prices and local concentration for the rest of the UK, which showed a positive association, should hold for the insurer-specific price index results as well as the average price index results.
- (g) The comparison between insured prices and local concentration was not reliable because it did not control for a range of factors that might influence insured prices.

6.359 In relation to outpatient treatments, we noted above that we were not able to include these treatments in our analysis of insured prices due to data limitations. The parties argued that if the price differences between hospital operators varied according to inpatient, day-case and outpatient treatments, then by omitting outpatient treatments our estimated price differences were not representative of all expenditure and were therefore biased. However, we received very limited evidence that indicated there was cross-subsidization between inpatient, outpatient and day-case treatments.<sup>481</sup>

We also noted that our review of the qualitative evidence on the bargaining between hospital operators and PMIs did not indicate any substantive differences in this regard (ie there was no evidence that hospital operators or PMIs systematically cross-subsidize between treatments). We therefore do not have strong reasons for expecting the exclusion of outpatients to materially distort our price comparisons.

6.360 In relation to the representativeness of the common basket of treatments used in our insured price analysis, we have set out earlier and in Appendix 6.12 the proportions of revenue accounted for by the treatments that we have analysed (see paragraph 6.339 and Appendix 6.12, Annex B, Table 1, and Annex C, Table 1). We have also conducted a sensitivity analysis that shows the conclusions of our price comparisons are robust to changes in the common basket of treatments (eg by increasing the size of the common basket). Furthermore, as noted in the previous paragraph, our review of the qualitative evidence on bargaining did not suggest that there is any systematic cross-subsidization between treatments. We therefore think it is reasonable to treat the price differences we have estimated using the common basket of treatments as representative of the price differences for all treatments. In relation to the smaller PMIs, for which the common basket typically contains fewer treatments and uses less data, we acknowledge that this may mean that these results are less robust than those for the larger PMIs. However, we considered that our use of the average price index, which places more weight on the larger PMIs, addresses this concern.

6.361 In relation to the comparability of the data used in our analysis of insured prices between hospital operators, HCA and Nuffield told us that they had concerns in this regard. Both parties argued that flaws in the data meant that our price comparisons were not on a like-for-like basis. HCA told us that the way PMIs were billed for treatments that were sometimes administered multiple times might differ between hospital operators, and that it did not fully recognize a small proportion of the Healthcode

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<sup>481</sup> Spire provided analysis from an internal document that it claimed showed, [§<], that it had negotiated relatively higher inpatient treatment prices and relatively lower outpatient treatment prices. It argued that this showed that the exclusion of outpatient treatments from our analysis could significantly alter the price index results. Unlike our analysis, however, the Spire analysis did not control for patient mix and we therefore did not place weight on the results.

invoices we had used in our analysis (less than 1 per cent).<sup>482</sup> Nuffield told us that it priced its inpatient treatments on a package basis, which included the cost of certain pre-assessment and post-operative treatments as well as the cost of any readmission following the main inpatient treatment. Nuffield's view was that the other operators differed in this regard and did not include these additional costs, meaning that Nuffield's price was overstated in our analysis. Nuffield provided us with some analysis prepared for this inquiry indicating that the readmission rate is very low, and typically accounts for less than 0.5 per cent of its patients; and the proportion of its costs associated with pre-assessment and post-operative treatment is on average around 10 per cent of total cost associated with the cost of services included in its package price.

6.362 We were not able to verify the assumptions used by Nuffield in its internal analysis, nor assess whether these pre-assessment and post-operative treatments were included or excluded from other operators' inpatient price. We also noted that Nuffield did not provide us with any internal documents produced in the normal course of business that analysed this issue, for example in the context of negotiations with PMIs. Overall, we considered that while the issues raised by HCA and Nuffield could add some uncertainty to the results of our price index analysis, particularly in cases where the difference in price between operators is small, the issues were not sufficient to undermine our confidence in the larger price differences and the positive association between insured prices and local concentration that we observe. Moreover, we have not placed weight on small price differences.

6.363 In relation to quality differences, and recognizing that there is a lack of objectively comparable measures of quality, as discussed in paragraphs 6.386, 6.412, 6.418, 6.437 and 6.440, we considered that the evidence available to us did not lead us to conclude that there are material differences in quality at the operator level between the hospital operators we compare among HCA and TLC, on the one hand, and BMI, Nuffield, Spire and Ramsay on the other. We also note that the evidence available to us did not suggest that PMIs, when negotiating, materially differentiate between the hospital operators in terms of quality (at the operator level, although we note that differences in quality between hospitals at the local level may exist). By separating our analysis between central London and the rest of the UK we have allowed for any material quality differences between the operators, on average across their portfolios of hospitals, in these two areas. We note that there may be differences in quality between individual hospitals, but again the lack of data on quality measures makes quality difficult to assess and we do not consider any such differences based on available evidence to be material to the results of our empirical analysis.

6.364 In relation to costs differences, we make two initial general observations. First, we considered that only marginal costs (as opposed to fixed costs) should be relevant for pricing decisions. Second, to the extent that we are comparing companies that compete with each other (for the same product in the same location), we would expect companies' prices to be determined by the costs of the most efficient operator and not by each company's own costs. For the purpose of this analysis, and recognizing that there is some product and geographic differentiation between hospital operators, our view is that relevant cost differences are those arising from: any differences in the mix of treatments and patients between hospital operators; any differences in the quality of the services provided by different hospital operators; and any local or regional variation in (some) input costs. As we did not find on the available evidence any material differences in quality across the hospital operators we com-

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<sup>482</sup> HCA provided one example of a treatment included in the common basket of treatments that we have analysed that can be administered multiple times.

pared, we considered it unlikely that there are marginal cost differences as a result of quality differences that we should account for.

- 6.365 Our analysis took other potential marginal cost differences into account in the following ways: separating the comparisons between central London and the rest of the UK such that any differences in marginal cost between these regions (eg labour costs) is controlled for; the price index methodology accounts for differences in treatment mix by focusing only on a common basket of treatments; and the price index methodology accounts for differences in patient mix by using regression analysis to control for differences in age, gender and length of stay. HCA told us that there were clinical reasons why the episode charges may not be comparable between patients and therefore hospital operators. It gave as examples: some treatments required being administered multiple times; the ability of a hospital operator to undertake related treatments if complexities arose; the requirement for additional services such as pathology; and the consumables and drugs required.
- 6.366 Our analysis does not explicitly control for the impact of these clinical factors on episode charges. However, we noted that, for the majority of treatments included in our analysis, the regression analysis controls for the majority of the variation in episode prices, and we did not have evidence to suggest that any remaining differences between patients (eg due to clinical reasons) were materially different between HCA and TLC (or indeed between BMI, Spire, Nuffield and Ramsay).
- 6.367 We also considered whether the charity status of certain hospital operators (TLC and Nuffield) may affect our price index results. HCA pointed out that TLC may have a cost advantage as a result of its charity status. We noted that HCA calculated this cost advantage to be the sum of corporation tax relief, business rates relief and VAT savings. Since corporation tax is applied to net profits and business rates are fixed costs, we would not expect either of these to be relevant for pricing. Regarding VAT, we considered the likely impact that this may have and found it to be small.<sup>483</sup> Taking these two points into consideration, we therefore did not consider charity status to have a material impact on the price comparisons. We also note that, in the context of the divestment remedies, HCA told us that it benefited from economies of scale across its hospital network (see paragraphs 11.180 and 11.195). This would lead to a cost advantage vis-à-vis TLC. Finally, we observe that the parties did not provide evidence of further cost differences (other than the evidence related to quality differences and charity status) between the operators that we compared.
- 6.368 In summary, we considered that our analysis has taken account of the relevant cost differences that are likely to be substantive, and any remaining cost differences are likely to be small and/or not affect pricing decisions.
- 6.369 In relation to retroactive rebates, we determined that various types of retrospective rebates exist in the contractual arrangements between hospital operators and PMIs. These can have the effect of lowering the effective price charged to a PMI.<sup>484</sup> Our price index methodology, which is based on invoice data, does not include any rebate paid retrospectively. We have reviewed the level of rebates actually paid by hospital operators to PMIs between 2007 and 2011 and found that only three PMIs

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<sup>483</sup> As regards VAT, it is our understanding that this relates, at least to a significant degree, to overhead (ie fixed) costs (eg legal and accountant fees). It follows that of the £10 million charity status benefits estimated by HCA for TLC for 2011, only a portion of the £3 million VAT savings is likely to be relevant for insured prices. The relevant VAT savings are comparable to a 2011 cost base of £[redacted] million. Thus, even if no VAT savings are related to fixed costs (ie all of the VAT savings are relevant for insured prices) and even if all of the assumptions behind this estimate (which we have not verified) are correct, this only accounts for savings of around [redacted] per cent of the cost base, which is substantially smaller than the price difference that we have estimated.

<sup>484</sup> We asked PMIs to provide details of all rebates paid between 2007 and 2011. In response, [redacted].

were paid rebates during this period and no PMI received a rebate in every single year. On the whole, however, the value of these rebates is small as a proportion of the total fees paid.<sup>485</sup> We therefore considered the likely impact on our price comparisons to be small.

6.370 In relation to the comparison between insured prices and our measures of local concentration for the four national hospital operators, BMI and Spire highlighted that the positive association between insured prices and local concentration that we observed when using the average price index was different, and in some cases the opposite (ie negative), when the insurer-specific price index was used. As noted in paragraph 6.352, we agree with the parties that there is an inconsistency in the price index results for BMI, Nuffield, Ramsay and Spire between the insurer-specific results and the average price results. We have not been able to explain this inconsistency.<sup>486</sup> These issues do not apply to central London, where our insurer-specific price index results are consistent with our average price index results.<sup>487</sup> Regarding the parties' argument concerning the association between insured prices and local concentration, however, we considered that it was appropriate to compare the average insured prices with local concentration (rather than the insurer-specific prices) since our local concentration variables are only measured on average across PMIs.<sup>488</sup>

6.371 In relation to the reliability of our comparison between insured prices and local concentration, we agreed with the parties that there are several factors as well as local concentration that may influence insured prices. We discussed our considerations in relation to cost and quality differences above. HCA told us that the following factors would also be expected to affect the distribution of bargaining power between hospital operators and PMIs, specifically their inside and outside options: the markets in which the PMIs operate; the nature of contracts with corporate clients (eg with respect to guided or open referral clauses); the responsiveness of corporate clients; switching costs for a corporate PMI client wishing to change PMI; the ability of a PMI to delay, at least temporarily, a treatment (until after a temporary delisting); the proportion of locked-in patients due to existing medical conditions; the volume of any pent-up demand (eg from NHS waiting lists); the 'consultant drag' effect; the parties' financial strength; and spare capacity. We noted that many of these factors are unobservable in the data and thus we have not been able to analyse them. We therefore considered whether and how the omission of these factors may have distorted the results of our comparisons of insured prices and local concentration (see Appendix 6.12, paragraph 72). Overall, we considered that while we cannot rule out that these factors may have by chance influenced the positive association that we observe, this influence may go in either direction (ie may be positive or negative), and it is unlikely to be sufficient to fully explain large price differences.

### ***Parallels between insured and self-pay price concentration analyses***

6.372 Given that we found a significant positive relationship between local concentration and self-pay prices in the PCA, for which a substantially larger amount of data is available than for the analysis of insured prices, we considered whether this finding provides some support of a similar relationship for insured prices.

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<sup>485</sup> The value of a rebate is typically less than [%] per cent of the total expenditure between a PMI and a hospital operator during the year, and no rebate exceeded [%] per cent.

<sup>486</sup> There are two notable inconsistencies. First, BMI, Nuffield and Spire charge similar average prices, but the insurer-specific results show that these operators charge materially different prices from [%]. Second, Ramsay is the lowest-priced operator on average, but the insurer-specific results show that [%].

<sup>487</sup> As previously noted, the exceptions to this are [%] in 2008 and [%] in 2007.

<sup>488</sup> We did not have measures of local substitutability that were specific to each PMI.

- 6.373 The number and size of customers are substantially different in the PMI and self-pay segments as hospital operators face a small number of large PMIs in the former and a large number of individual patients in the latter. Accordingly, the self-pay segment is broadly characterized by list (or take-it-or-leave-it) prices set by hospital operators, while the PMI segment is characterized by negotiated prices.
- 6.374 However, the same hospital operators are the suppliers for both segments and both PMIs and self-pay patients have related outside options at the local level. In particular, both PMIs and self-pay patients will consider the availability of rival hospitals to which they can switch in their response to hospital operators. The availability of substitutable rival hospitals, as proxied by local concentration, is thus a determinant of prices for similar reasons in the self-pay segment as in the PMI segment.
- 6.375 We recognized that the approach to price setting is different in the PMI and self-pay segments, the former resulting in average prices across hospitals of the same operator (national prices), the latter resulting in prices set at hospital level (local prices). While this, in itself, will impact the observed sensitivity of the prices to differences in local concentration, with local self-pay prices being more sensitive to local concentration differences than national insured prices, for which any effect is diluted by the averaging, we considered that this does not undermine the argument that buyers' outside options are a driver of prices for both segments. However, as discussed in paragraph 6.343(c), national pricing makes our empirical analysis of the relationship between insured prices and local concentration outside central London more difficult to interpret than the corresponding analyses for central London and for self-pay prices.
- 6.376 Based on the above reasoning, we considered that the finding of a significant positive relationship between local concentration and prices in the self-pay segment provides some support for the existence of an analogous relationship between local concentration and prices in the PMI segment. In particular, the relationship between local concentration and prices is driven by the outside options of the customers, which for both segments are determined by the availability of substitutable rival hospitals at the local level.

### ***Conclusions on insured prices***

- 6.377 Internal documents reporting the planning of negotiations by both hospital operators and PMIs showed that:
- (a) the competitive position of hospitals at the local level is an important factor that both PMIs and hospital operators take into consideration in their negotiations over insured prices; and
  - (b) the PMIs and hospitals operators are dependent upon each other and it does not appear that either side anticipates it would survive without substantial damage in the event of a sizeable delisting. This suggests that both these parties to the negotiations have some degree of bargaining power, also depending on the strength of their outside options.
- 6.378 The self-pay PCA also provides some support for the existence of an analogous relationship between local concentration and prices in the PMI segment.
- 6.379 We conducted an empirical analysis of insured prices for inpatient and day-patient treatments. The purpose of the analysis was twofold: (a) to examine the relationship between local concentration and insured prices; and (b) to assess the degree of the relationship.

- 6.380 We found consistent results in relation to HCA and TLC in central London that supported the conclusions that HCA faces weak competitive constraints from its rivals in central London, even from its closest competitor TLC (as reflected, for example, in their respective shares of supply). In particular, we found that HCA charges significantly higher prices to PMIs than TLC. We found this to be the case on average across PMIs, and for the large majority of individual PMIs [§], for each year between 2007 and 2011 inclusive. Over this period, HCA charged prices to PMIs that were on average [§] per cent higher than TLC. In addition, in relation to the prices paid by PMIs relative to self-pay patients for HCA, we found that [§] paid prices that were similar to, and in a small number of cases up to [§] than the prices paid by self-pay patients, [§] paid prices to HCA that are higher than the prices paid by self-pay patients on average in 2007 to 2011.
- 6.381 Notwithstanding the limitations of our empirical analysis (see paragraphs 6.343(a) to (c) and 6.371) and 6.392(a)), we considered that, overall, for central London, the results of our empirical analysis all support our hypothesis that local substitutability plays a role in determining insured price outcomes and provide an indication of the magnitude of the relationship between local concentration and insured prices.
- 6.382 In relation to BMI, Spire, Nuffield and Ramsay outside central London, our results are mixed. We found that:
- (a) Ramsay is the lowest-price operator on average across PMIs and is also characterized by the least concentrated portfolio of hospitals relative to the other three operators. Nuffield and Spire have broadly similar prices and are characterized by similarly concentrated portfolios of hospitals. BMI, Nuffield and Spire have broadly similar prices but BMI's portfolio is characterized by higher concentration than that for Spire and Nuffield.<sup>489</sup>
  - (b) The insurer-specific price index results, [§], were not consistent with the average price index results.
  - (c) Relative to the prices paid by self-pay patients at each of the four national hospital operators, [§] on average over the period 2007 to 2011. This is also the case for [§] generally pay prices at least as high as self-pay patients.
- 6.383 Notwithstanding the limitations of our empirical analysis (see paragraphs 6.22, 6.343(a) to (c) and 6.48), we found that whilst some of the results are broadly consistent with our hypothesis that local substitutability plays a role in determining insured price outcomes, other results are not.

## **Quality and range**

### *Introduction*

- 6.384 Competition in private healthcare provision is characterised by hospital operators positioning themselves in terms of quality, range and price.<sup>490</sup> Quality indicates how well a given treatment and the overall service are provided (also referred to as vertical product differentiation). Quality may refer to different aspects, including

<sup>489</sup> We are referring to the proportion of hospitals of concern in each operator's portfolio as a measure of average local concentration.

<sup>490</sup> HCA often referred in its submissions to 'innovation' as another dimension of non-price competition in the provision of healthcare. As we discuss in what follows, in this market 'innovation' mainly refers to the adoption of existing products, technologies, equipment, rather than the development of new ones. For this reason, we consider that non-price competition is adequately described in terms of quality and range.

clinical expertise and outcomes, nursing care, waiting time, comfort and quality of accommodation. Consultants are themselves a quality component of a hospital operator's offer (from a patient's point of view). Range indicates which and how many treatments are provided (also referred to as horizontal product differentiation) and it encompasses the extent to which hospital operators provide more complex, and possibly more costly, treatments (ie high acuity care). In our view, it is appropriate to maintain a clear distinction between quality and range and not make inferences about the level of quality of a hospital operator's offer from the range of treatments it provides (for example, inferring higher quality from the higher degree of complexity of the treatments provided).

- 6.385 In order to improve the quality or expand the range of the treatments provided, hospital operators may have to incur some investment, which may vary significantly in size (from being small and incremental to being large and lumpy). Some quality improvement or range expansion may not involve any investment, and only affect operating costs (eg the introduction of a treatment not previously provided within a specialty already offered by the hospital). Hospital operators' decisions over their quality and/or range offer, and over the investment possibly required, can be influenced by a number of factors: competition (ie with a view to rivalry); regulatory compliance; and the exploitation of market opportunities. Decisions that are driven by competition can be 'offensive' (the firm acts as a first mover with the purpose of attracting business from rival hospital operators) or 'defensive' (the firm acts as a follower with the purpose of preventing a rival from attracting additional business).
- 6.386 In the provisional findings, whilst we did not carry out any analysis of non-price market outcomes in their own right, we did address the extent to which quality differences may explain the price differences we found. On quality, we have received no evidence that quality is generally a concern in relation to private hospital services. We considered that it would be extremely difficult for the CC to assess quality in relation to the provision of private hospital services as there is a lack of objectively comparable measures of quality. As set out in Section 9, we have found that information on the performance of hospitals is not readily available. Therefore, we considered that any analysis of quality in its own right would be extremely resource intensive and likely to be inconclusive. We therefore focused our resources on in particular price rather than quality outcomes.
- 6.387 Since our provisional findings, we have not attempted to analyse non-price outcomes to the same extent as we have done for price and profitability outcomes. Some parties, primarily HCA, in response to our provisional findings, our Remedies Notice and our provisional decision on remedies, argued that quality and range were highly relevant to the hospital AECs we had provisionally identified as well as to our proposed remedies. In this section, we review and address the main arguments raised by the parties and, in particular, by HCA, in relation to non-price outcomes. As noted, some of HCA's arguments were raised in the course of our remedy process and are discussed in more detail in Section 11. To the extent that we consider these arguments to be relevant for the present discussion, we summarize them here and set out our view. Where appropriate, we cross-refer to the detailed discussion in Section 11. This section is structured as follows: we first discuss central London, setting out HCA's views and our response; we then present the evidence for the rest of the UK; finally, we set out our conclusions.

## Central London

### HCA's views

6.388 HCA raised extensive comments in relation to competition over quality and range and its competitive position relative to that of other hospital operators, and argued that the provisional findings failed to take account of the role of quality and innovation in driving competition for both patients and consultants, particularly in London. We grouped these comments in the following categories:

- (a) competition in quality and range in London;
- (b) differentiation of HCA vis-à-vis other London hospitals;
- (c) differentiation of HCA vis-à-vis TLC;
- (d) economic theory and empirical studies on the effect of competition on quality; and
- (e) PMIs' incentives in relation to quality.

- *Competition in quality and range in London*

6.389 HCA told us that the competitiveness of the market, particularly in London, manifested itself in competition on quality, innovation and range of services (in particular, high-acuity care) to attract consultants and patients.

6.390 HCA also submitted that HCA's commitment to quality and excellence was driven by strong competitive pressures from other private providers, from the NHS, and also from other hospitals internationally, and that the business cases for HCA investments submitted to us were evidence of how HCA was incentivized to maintain and improve levels of quality and innovation to keep abreast of its competitors.<sup>491</sup>

6.391 Finally, HCA argued that competition over quality and innovation and product differentiation led to a dynamic investment process where improvements could lead to a temporary competitive advantage (eg by being the only provider to offer a given service) and in particular temporarily higher margins, thus providing an incentive for continuous investment to stay ahead of the competition. HCA also submitted that it had a practice of reinvesting its profits back into its hospitals and it currently reinvested over [§] per cent of its profits.<sup>492</sup>

- *Differentiation of HCA vis-à-vis other London hospitals*

6.392 HCA told us that it had acquired a number of central London hospitals in the late 1990s and early 2000s,<sup>493</sup> and that it invested heavily in subsequent years (over

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<sup>491</sup> HCA considered that continuous investment was required 'to compete effectively in high-end tertiary services' (see [HCA response to provisional findings](#), paragraph 2.9) and that 'the level of investment and innovation of HCA is a signal of the competitive pressures in the market' (see [HCA response to annotated issues statement](#), paragraph 5.150).

<sup>492</sup> HCA made various claims about its margins and profit reinvestment. It told us that 'innovative products tend to earn high prices and margins when introduced' and that 'the presence of high prices per se is not an indication of market power in a context where the margins earned as a result of the higher prices are reinvested in the business'. HCA also submitted that its 'prices, margins and practice of reinvesting its profits back into its hospitals reflect the competitive nature of the market and its product differentiation' ([HCA response to annotated issues statement](#), paragraph 5.150), that 'The CC has not asked itself what, if not competition, has compelled HCA to engage in such a strategy that would see it reinvest [§] per cent of its net profits back into its hospital to improve quality and choice for patients' ([HCA response to provisional decision on remedies](#), paragraph 4.14), and that 'it has invested heavily in its facilities and clinical staff over the years, specifically, HCA currently reinvests over [§] per cent of its profits in order to provide the highest quality care to patients' ([HCA response to issues statement](#), p3).

<sup>493</sup> See [HCA response to provisional findings](#), p21.



£[redacted] million in the last 10 to 12 years),<sup>494</sup> with the aim of transforming its acquired hospitals into world-leading hospitals.

- 6.393 HCA considered that its strategy, in focusing on high-quality, high-acuity tertiary care, had differentiated its clinical offering in London. In particular, HCA told us that it competed, within a broad product and geographic market, alongside lower-quality and lower-cost providers, with competition between these providers driving vertical as well as horizontal differentiation.
- 6.394 HCA also argued that having a larger scale allowed it to invest in certain niche procedures and technologies and sub-specialisms that would not be sustainable at a smaller scale. However, HCA noted that investment in such services was only one of the types of investment that resulted in a private healthcare provider's offering being more or less appealing to customers and as such hospital operators of a much smaller scale could still provide a substantial competitive constraint on HCA.
- 6.395 HCA further submitted that it could justly claim a strong quality record, relative both to the NHS and its private sector peers, and it cited a number of examples of 'metrics against which it scores higher than its peers'.<sup>495</sup> HCA also provided a list of examples in support of its own high quality,<sup>496</sup> its own readiness to introduce new treatments/equipment and the investments it had made in this respect.<sup>497</sup>

- *Differentiation of HCA vis-à-vis TLC*

- 6.396 In line with the considerations above, HCA argued that its quality and range of services (in particular complex, tertiary treatments) were superior to those of TLC.
- 6.397 In particular, HCA submitted that while the CC was right to identify TLC as a significant, successful and close competitor to HCA, noting that TLC had successfully launched, within a very short space of time, a major new cancer centre and competed vigorously with HCA on a wide variety of clinical services,<sup>498</sup> there were nevertheless important ways in which HCA's service offering could be differentiated from that of other providers such as TLC on grounds of quality of care, resulting in significantly higher costs for HCA. HCA went on to list a number of examples in support of its claim.<sup>499</sup> It also recognized that quality could be difficult to measure and that there was limited public data which enabled quality comparisons to be drawn.

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In 1996, HCA and PPP Healthcare Limited jointly acquired the Harley Street Clinic, Portland, Princess Grace and Wellington Hospitals from BMI. BMI divested these London hospitals because of the high cost of operating them in an increasingly competitive landscape. HCA had a different vision for the future of the hospitals, namely to transform them through large-scale investment and clinical expertise into world-leading hospitals that can offer complex care that was otherwise only available in the NHS. In 2001, HCA took over the London Bridge, the Lister and the Arrazi hospitals through its acquisition of St. Martin's Healthcare Limited from the Kuwait Investment Office.

<sup>494</sup> See [HCA response to provisional findings](#), paragraph 2.8 and Table 3.1, HCA major investments in London, 2000-2012, which lists investments totalling to £[redacted] million for 2000-2006, £[redacted] million for 2007, £[redacted] million for 2008, £[redacted] million for 2009, £[redacted] million for 2010, £[redacted] million for 2011, £[redacted] million for 2012 and £[redacted] million for 2013 (we note that the figure for 2013 was compiled prior to the end of 2013). This includes expansions, refurbishments, upgrades as well as £[redacted] million for UCH NHSV in 2000-2006, £[redacted] million for LOC and £[redacted] million for Christie Clinic NHSV in 2010, £[redacted] million for the PMC in 2011 and £[redacted] million for Wilmslow Outpatient and Diagnostic Centre in 2013.

<sup>495</sup> HCA told us that it was the only private hospital operator to have achieved a 100 per cent compliance with all CQC clinical outcomes; it had the first and only private integrated rehabilitation unit in the UK to win quality accreditations; its unplanned returns to the operating theatre were over ten times lower than the national average; and it boasted a string of quality awards, including the 2013 Health Investor Public/Private Partnership Award ([HCA response to provisional findings](#), paragraph 2.11).

<sup>496</sup> HCA's examples in relation to the quality of its services are reported in Appendix 11.1, paragraphs 4-7.

<sup>497</sup> See [HCA response to provisional findings](#), Table 3.1.

<sup>498</sup> HCA told us that TLC offered a comprehensive range of services ranging from routine medical care to complex procedures, that TLC had invested in state-of-the-art equipment such as the Da Vinci robot and an endoscopy unit, and that TLC recently opened a new £80 million cancer centre.

<sup>499</sup> HCA said that it invested more than TLC in staff to support capital investment, namely: (a) HCA employed more Resident Medical Officers (RMOs) and Clinical Nurse Specialists (CNSs) than TLC; and (b) HCA offered patients a high nurse:patient

- *Economic theory and empirical studies on the effect of competition on quality*

6.398 HCA considered that, in the context of a market where both price and quality were variable and price was negotiated with a buyer group, economic theory provided no clear predictions on the effect of competition on quality. Price competition alongside imperfectly observed quality could result in lower quality. For example, if patients had little choice but to attend the hospital chosen by a healthcare buyer which required the lowest procurement price subject to a minimum quality standard, there was an incentive for hospitals to cut cost and unobservable aspects of quality. HCA noted, in relation to competition and innovation, that economic theory suggested that there was no simple monotonic relationship between measures of competition and innovation and that a widely-cited econometric paper found an inverted U shaped relationship.<sup>500</sup>

6.399 In situations where economic theory was ambiguous about the effect of competition on quality, HCA said it was important to use empirical research to help determine the relationship between greater competition and quality. It considered that empirical research in the UK showed that mortality rates in the NHS did in fact increase in more competitive local markets (but easily observable waiting lists were shorter).<sup>501</sup> HCA additionally cited research by Professor C Propper stating that:

Research for the UK showed that when competition was introduced in the early 1990s in an NHS regime that allowed hospitals to negotiate prices as well as quality, there was a fall in clinical quality in more competitive areas. This is confirmed by research in the US healthcare market: where prices are set as part of the bargaining process between hospitals and buyers of healthcare, competition tends to be associated with poorer quality.<sup>502</sup>

- *PMIs' incentives as regards quality*

6.400 HCA submitted that the CC did not consider the crucial difference between PMIs and patients in their preference for quality. In setting out this argument, HCA contrasted the provision of private medical insurance with that of private motor insurance, which was the subject of a CC market investigation at the same time as the CC was investigating private healthcare provision.

6.401 HCA noted that an insurer did not have the same trade-off between quality and price as the insured party. While PMIs had an incentive to increase revenue by selling

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ratio ([HCA supplemental submission following remedies hearing](#), paragraph 6.4). In relation to quality of clinical services, HCA said that (a) it invested in specialties that TLC did not offer to its patients, for example in paediatrics, neuro-rehabilitation, and, whilst TLC did provide a limited range of cardiac and gastroenterological services, it did not offer the same depth of services as HCA in these specialties; (b) it operated its own, wholly-owned clinical research unit for cancer patients (at SCRI which HCA said was the only CQC-accredited private research centre in the UK offering clinical trials to NHS and private patients), which it had integrated into its cancer network; (c) in some cases, HCA had a quality advantage through its network approach to service delivery (eg HCA's NHS JV at UCH performed a higher number of bone marrow transplants than TLC); (d) feedback from clinicians indicated that HCA outperformed TLC on a number of quality aspects; (e) it performed better than TLC on various quality comparisons which were publicly available, for example HCA had markedly lower infection rates than TLC ([HCA supplemental submission following remedies hearing](#), paragraphs 6.6, 6.8–6.12 and 6.15–6.18). Finally, HCA believed that, across its hospital facilities, it was able to offer patients a higher level of comfort and customer service ([HCA supplemental submission following remedies hearing](#), paragraph 6.14). We note that in response to the provisional findings, HCA told us that (a) it employed onsite RMOs and CNSs which were present at all times whereas HCA understood that TLC did not employ onsite RMOs and instead had them on call from agencies; and (b) HCA offered patients a higher nurse:patient ratio, which HCA said was 0.33 compared with 0.25 for TLC ([HCA response to provisional findings](#), Appendix 4, Analysis of Insured Prices).

<sup>500</sup> The paper mentioned is Aghion, P, Bloom, N, Blundell, R, Griffith, R, & Howitt, P (2005): 'Competition and Innovation: An Inverted-U Relationship', *The Quarterly Journal of Economics*, 120(2), 701–728.

<sup>501</sup> Propper, Burgess and Gossage (2008) 'Competition and quality: evidence from the NHS internal market 1991-9', *The Economic Journal*, 118, 138–170.

<sup>502</sup> Propper, 'Healthcare competition saves lives', Research in *Public Policy*, Winter 2010, p20.

more policies at a higher premium (by recognizing higher-quality/wider range providers), they also had an incentive to minimize claim costs. HCA claimed that, given that, at the point of purchasing a private medical insurance, customers were more likely to consider simple metrics, such as price and location of hospitals, than the details of quality and range of specialties and sub-specialties provided by the hospitals covered by the PMI, in practice, this trade-off was likely to result in PMIs favouring cost reduction over higher quality and a wider range of private healthcare services (that might otherwise only be available in the NHS).

- 6.402 HCA further noted that in the motor insurance investigation we had accepted that the reputation of providers might play a crucial role in helping consumers who could not easily judge quality. It said that in motor insurance it was the weakness of reputational effects for repair shops that caused the AECs, which contrasted with health-care where, according to HCA, such reputational effects were much stronger.
- 6.403 HCA further argued that, through the implementation of restrictive networks (ie insurance policies that limited the hospitals that could be used by policyholders), PMIs could exert bargaining power against HCA while at the same time limiting the quality distortion caused by their own incentive to minimize claim costs. Finally, in relation to incentives for PMIs, it noted that the combination of better quality indicators and PMIs' restricted networks would help further reduce the distortion of the price-quality trade-off between PMIs and insured patients at the same time as raising PMI bargaining power.

#### *Our assessment*

- 6.404 We now address HCA's points in order.

- *Competition in quality and range in London*

- 6.405 In relation to HCA's argument that investments in quality and range are evidence of a competitive market in London (see paragraphs 6.389 to 6.391), we note that the existence of investments in quality and range is not inconsistent with a market being highly concentrated as, in general, firms with market power may also find it worthwhile to improve quality and expand range (see paragraph 6.420). HCA agreed with this (see paragraph 6.421).
- 6.406 We have considered the business cases HCA submitted to us, outlining its major investments, to determine the extent to which these investments were driven by HCA's consideration of the competitive constraints it faces.<sup>503</sup> In this regard, we make a number of observations:
- (a) First, HCA's investments set out in these business cases are frequently accompanied by a consideration of its private competitors in central London as opposed to private competitors outside central London.<sup>504</sup> Of particular interest to HCA in a number of its investment decisions appears to have been TLC's investment in a new cancer centre, but other competitors, for example Bupa Cromwell,

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<sup>503</sup> We have reviewed the 20 business cases provided by HCA in response to Question 7 of the Financial Questionnaire, which asked for business cases for all major capex (>£500,000). Unless stated otherwise, the business cases we discuss refer to these business cases. While our focus has been on these business cases, for which we have been provided with internal documents, we note that further business cases are mentioned in Appendix 7 of [HCA's response to provisional findings](#).

<sup>504</sup> Roughly half of the business cases considered make mention of private competitors in central London. Only one of these business cases, [§] makes mention of a private competitor from Greater London [§]. Moreover, the business cases mentioned in Appendix 7 of [HCA response to provisional findings](#) refer almost exclusively to central London competitors. See also paragraph 6.226.

are also taken into consideration in most of the cases that consider private competitors in central London.<sup>505</sup> These investments are sometimes offensive and sometimes defensive in nature (see paragraphs 6.385 and 6.411).

- (b) Second, some of the investments are accompanied by considerations of the NHS<sup>506</sup> or business from international patients.<sup>507</sup> In our view, these investments are indicative of HCA's aim of expanding its private business rather than of competitive constraints imposed on HCA by the NHS and international providers. We address HCA's view on competitive pressure from the NHS, and the evidence from HCA's business cases, in paragraphs 6.245 to 6.247. In relation to HCA's view on competitive pressure from international providers, we think that similar considerations as those highlighted for the NHS apply. In particular, while the aim of attracting international business may provide HCA with an additional rationale for expanding its range or improving its quality, such range and quality decisions are not indicative of the strength of the competitive constraints faced by HCA with respect to its UK private business, ie international providers do not constrain HCA's actions with regard to range and quality (and price) for its UK private business. In our view, it is significant that only a very small number of the business cases took into consideration business from abroad and that not a single business case we reviewed mentioned competitors from abroad (as opposed to local competition for international business<sup>508</sup>).
- (c) Third, a significant number of HCA's investments seem to be driven by maintenance or regulatory requirements (eg by the CQC's predecessor, the Healthcare Commission) and, as such, are not relevant for the assessment of competitive constraints faced by HCA.

6.407 Overall, our view is that the evidence provided by HCA (see paragraphs 6.390 and 6.411) showed that over the past years various hospital operators in central London, including HCA and TLC, have expanded the range of treatments provided (including complex treatments) and have incurred investments to expand and/or improve the product offer at their hospitals (for example, through the adoption of new equipment or hospital expansions and refurbishments). These decisions were sometimes accompanied by a view of attracting consultants.<sup>509</sup> The evidence available on quality improvements by the various hospital operators in central London, as we discuss in more detail below, is far more limited (see paragraphs 6.412, 6.417 and 6.418).

6.408 Our review of HCA's business cases (see paragraph 6.406), however, suggests that HCA has overstated the link between its investments and the degree of the competition it faces from private UK providers (in particular outside central London), the NHS and international providers. In a significant number of the business cases we reviewed, investment decisions were not driven by considerations of competitive constraints and, where they were, the focus of HCA's interest was, in the majority of

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<sup>505</sup> Exceptions to this are the business cases [X], which focus on competition from TLC. See the business cases mentioned in Appendix 7 of [HCA response to provisional findings](#) for further references to HCA's private competitors in central London.

<sup>506</sup> See in particular the business cases [X]. The business cases mentioned in Appendix 7 of [HCA response to provisional findings](#) scarcely refer to the NHS except for ITU investments.

<sup>507</sup> See in particular the business cases [X]. We note that in the former case the investment is driven also by local factors. The business cases mentioned in Appendix 7 of [HCA response to provisional findings](#) scarcely refer to international business.

<sup>508</sup> See in particular the business case [X]. The business cases mentioned in Appendix 7 of [HCA response to provisional findings](#) only mentions the Cleveland Clinic.

<sup>509</sup> HCA told us that the specialist consultants required to deliver safely the type of complex treatments demanded by patients were often based in London. Given the greater focus on quality by patients, it was imperative that HCA attracted the top consultants, particularly given that patients also had access to the consultants practising at major NHS teaching hospitals, such as Guy's and St Thomas', St Bartholomew's, King's College, UCH, the Royal Marsden, all of which hosted leading practitioners in their respective fields.

cases, on a narrow set of private competitors in central London, the main one being TLC, which in our view imposes a weak constraint on HCA.

6.409 We now consider HCA's view that temporarily higher margins may result from a dynamic investment process and that HCA has been reinvesting most of (currently all) its profits back in its hospitals (see paragraph 6.391). While we agree that temporarily high margins may result from investments, we note that HCA does not appear to have invested over recent years more than its closest competitor, TLC,<sup>510</sup> and HCA's profitability is significantly higher (see Appendix 6.13). We further note that we disagree with HCA in that it does not appear to us that HCA has reinvested [§] its profits.<sup>511</sup>

- *Differentiation of HCA vis-à-vis other London hospitals*

6.410 As discussed in paragraph 6.384, we agree with HCA that private hospital operators may be characterized as being horizontally and vertically differentiated (see paragraph 6.393). Operators offering a wider range of treatments (including high-acuity treatments) and/or a higher quality may coexist with operators with a narrower range of treatments and/or a lower quality. Hospital location is another element of this differentiation. In such a context, the stronger competitive constraints typically arise from competitors closer to each other over the various competitive dimensions, ie range, quality and location. As explained in paragraph 6.218, and as further argued in this section, the evidence submitted to us indicates that HCA's closer competitors are hospital operators in central London and that HCA and TLC are the closest. In our view, the evidence submitted by HCA confirms that this is the case (see, for example, paragraph 6.406(a) and Appendix 6.10, Annex A, paragraph 16).

6.411 Focusing on product range, we acknowledge that HCA has a relatively strong focus on high-acuity care and that it has been the leader in introducing a range of treatments/diagnostic techniques. We note, however, that HCA also told us that when HCA had been 'first to market' with new treatments/diagnostic technologies, competitors had been relatively quick to follow suit and that, similarly, HCA had responded to other competitors' investments. HCA added that the need to 'keep up' with the competition was by no means isolated to just TLC and HCA. We note that in providing examples supporting this statement, HCA mostly referred to central London competitors.<sup>512</sup> This suggests that although there may be a degree of horizontal differentiation, this does not appear to be perceived by HCA as a significant differentiator between its hospitals and those of some of its competitors, in particular competitors in central London. We note that HCA's observation that the larger scale needed to invest in certain niche treatments and sub-specialisms does not prevent smaller-scale competitors from having an appealing offer to customers appears to point to the same conclusion (see paragraph 6.394). We discuss product range differentiation between HCA and TLC in paragraphs 6.414 to 6.416.

6.412 Considering quality, HCA claimed that its quality was higher than that of its competitors, and that it had provided a number of examples of its high quality (see paragraph

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<sup>510</sup> HCA reported to us that its total capital expenditure was around £[§] million between 2007 and 2011, compared with a total reported by TLC of around £[§] million for the same period. We note that HCA's figure is at odds with the capex figure of £[§] million it provided to us previously, in response to question 7 of the Financial Questionnaire. In either case, given the significantly smaller size of TLC, this indicates that TLC has invested proportionately more than HCA over the period.

<sup>511</sup> We consider the comparison between capex and operating profits (EBITDA) to be more appropriate than the net profit comparison made in [HCA's response to provisional findings](#) as depreciation reflects the costs of maintaining the asset base. Based on our analysis, HCA reinvested (on average) around a third of its operating profits into the business over the period FY2006–FY2012 and it was approximately in steady state prior to FY2010, ie it was investing at a level to keep its asset base stable rather than grow it.

<sup>512</sup> See [HCA response to provisional findings](#), paragraph 3.47, where HCA mentioned four cases. [§]



6.395). We consider HCA's specific examples in Appendix 11.1, paragraphs 27 to 38. We note here that, while we acknowledge that HCA has made investments to improve the product offer at its hospitals and that its hospitals have a reputation for being 'elite', similar considerations apply to some of its competitors' hospitals in central London (see, for example, Appendix 6.10, Annex A, paragraphs 7, 8, 16, 18 and 19). We further note that there is a lack of objectively comparable quantitative data on quality indicators, including clinical outcomes, and this has greatly limited our ability to compare the various hospital operators. Overall, we considered that the evidence available to us, including HCA's specific examples, did not lead us to conclude that HCA's quality was materially higher than that of close competitors in central London, for example TLC, St John and St Elizabeth and King Edward VII.

- *Differentiation of HCA vis-à-vis TLC*

6.413 We consider now the degree of differentiation existing between HCA and TLC as argued by HCA (see paragraphs 6.396 and 6.397). The considerations set out in paragraphs 6.411 and 6.412 remain relevant. We, however, highlight the following points.

6.414 In relation to product range, while HCA noted that it offered a broader range of complex, tertiary services than TLC (see paragraph 6.396), HCA also told us that it regarded TLC as offering a comprehensive range of services (including complex services) and owning state-of-the-art equipment (including a new £80 million cancer centre and, in particular, a Cyberknife, the DaVinci robotic surgery system and an endoscopy unit).<sup>513</sup>

6.415 As noted in paragraph 6.406(a), it appears that TLC has been particularly relevant to a number of HCA's investment decisions, in particular related to cancer treatments and as a result of TLC's new cancer centre, and that HCA has made both offensive and defensive investments in consideration of the competition it faces from TLC.<sup>514</sup> We also note that HCA considers TLC to be its closest competitor in its business cases relating to cancer services, not only in relation to the Harley Street Clinic but also to its other hospitals in central London.

6.416 Overall, we acknowledge that HCA offers a wider range of treatments than TLC, but we consider that TLC's offer is regarded by HCA as comprehensive.<sup>515</sup> As discussed in paragraph 6.213, we also consider that the difference in product range between HCA and TLC is likely to be explained to some extent by the difference in the sizes of their hospital portfolios and that both HCA and TLC have expanded their range in recent years.

6.417 HCA has provided a number of specific examples to support its view that its quality is superior to that of TLC (see paragraph 6.397). We considered these examples and note the following points:

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<sup>513</sup> Whilst these examples also relate to cancer services, HCA's view, that TLC provides a comprehensive range of services and state-of-the-art equipment, is provided in a more general context.

<sup>514</sup> [REDACTED]

<sup>515</sup> Our data supports this conclusion. Based on our cleaned Healthcode data set, we found that, in terms of patients, [REDACTED] per cent of HCA's patients seek treatments which are also offered by TLC. In terms of treatments, [REDACTED] per cent of treatments offered by HCA are also offered by TLC. In terms of revenue, [REDACTED] per cent of HCA's revenue is earned on treatments also offered by TLC. We also found that, between 2007 and 2011, TLC has spent around £[REDACTED] million on capex projects. Although the latter figure may not be 'typical' as during this period TLC was building its cancer centre, they demonstrate that TLC has also been investing significantly in the market and, as discussed in footnote 510, it has invested proportionately more than HCA over the period.

- (a) Some of the examples reflect the range rather than the quality of HCA's offering (for example, the range of specialties relative to TLC). We do not consider the fact that HCA has a wider range of treatments/specialties across its hospitals than TLC, some of which will be due to HCA being a much larger operator, as being evidence that HCA provides higher quality than TLC. We discussed our view in relation to range above.
- (b) Whilst HCA may employ more RMOs and CNSs than TLC, this is unsurprising given that it has more ITUs than TLC and does not indicate therefore that HCA is a higher-quality operator than TLC.
- (c) In relation to the nurse:patient ratio, we note that HCA's estimates for TLC are based on a generalized statement on TLC's website about TLC's minimum nurse:patient ratios. HCA then used a number of assumptions to calculate a difference in cost per patient between TLC and HCA as a result of these nurse:patient ratios, without providing underlying data which allows us to compare the figures for HCA and TLC.<sup>516</sup>
- (d) HCA has not provided data supporting its claims in relation to higher levels of comfort and customer service.
- (e) We have no indication of the representativeness of the feedback from clinicians and staff and would not consider evidence of this nature to be sufficient to conclude that HCA's quality is materially higher than TLC's.
- (f) As acknowledged by HCA, with the exception of infection rates, the other data is not publicly available.<sup>517</sup>

6.418 On the basis of the considerations set out in paragraphs 6.412 and 6.417, and noting that there is a lack of objectively comparable quantitative data on quality indicators, overall we considered that the evidence available to us, including HCA's specific examples, did not allow us to conclude that HCA's quality was materially higher than that of TLC.

- *Economic theory and empirical studies on the effect of competition on quality*

6.419 We agree with HCA that economic theory is ambiguous as to the effects of competition on quality and innovation (see paragraph 6.398), but, for the reasons discussed below, we consider that in private healthcare competition is expected to foster investments in quality and range.<sup>518</sup>

6.420 In general, competition may be characterized as having two effects on investments in quality and innovation. The first effect is that, by giving firms a competitive advan-

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<sup>516</sup> HCA said that its own nurse:patient ratio was [redacted] for general nurses. HCA obtained TLC's nurse:patient ratio from TLC's website, which states 'The nurse to patient ratio is very good—with one nurse looking after no more than four patients.' HCA then calculated the cost implications of this difference in nurse:patient ratio by assuming that these nurse:patient ratios applied to all nurses (ie not only general nurses), as well as making assumptions regarding the cost per nurse (including that it is the same for HCA and TLC). Using these assumptions, and on the basis of HCA and TLC's total admission figures, HCA estimated that the difference in nurse:patient ratio resulted in a cost difference of £[redacted] per patient treated. We were not able to verify HCA's nurse:patient ratio, the statement on TLC's website (ie whether it was comparable to HCA's stated ratio), or HCA's assumptions regarding the cost per nurse.

<sup>517</sup> As discussed in Appendix 11.1, paragraph 30, we reviewed CQC inspection reports concerning HCA hospitals. In its most recent report on each hospital, the CQC found that all the hospitals concerned met its standards. A CQC report on the Portland Hospital in February 2012 listed a number of areas where it had 'minor concerns' but, overall, the CQC reports were favourable. However, CQC reports for the same period on TLC, King Edward VII Sister Agnes and the Royal Marsden PPU were as positive as HCA's.

<sup>518</sup> As noted in footnote 490, we consider the term 'range' to be more appropriate than 'innovation' in the context of the provision of private healthcare. We use the latter term in a more general context.

tage, in terms of either margins or market share or both, competition stimulates investment (this effect can be referred to as ‘escape-competition effect’<sup>519</sup>). The second effect is that, by undermining firms’ ability to extract profits, competition discourages investment (this effect can be referred to as profit-extraction effect). The second effect is more likely to be significant in innovation-driven markets (such as R&D-intensive markets), where the size and the risk associated with investments in innovation are substantial. In this case, if market power was not protected (eg by means of patents), rivals would be able to adopt the technology and compete with the innovator without facing the associated R&D costs that the innovator faced, and the innovator would not be able to recoup its investment costs. This would undermine incentives to innovate in the first place. We consider that innovation-driven markets differ substantially from the provision of private healthcare, where, on the whole, firms choose to adopt a technology rather than developing it themselves. In markets such as the provision of private healthcare, any rival that wishes to adopt the new technology has to pay for it in much the same way as the firm that first adopted it.

- 6.421 We note that we have seen some evidence of investments in central London, in particular by HCA and TLC in cancer care, that were driven by the increase in competition that HCA faced as a result of TLC’s new cancer centre (see paragraph 6.406(a)). We have made similar findings outside central London (see paragraph 6.434), where we have seen entry or threats of entry leading to investments in expanding the range and/or improving the hospital product offer. As such, it is our view that competition as a whole is expected to foster investments in range and quality (ie the first effect referred to above dominates the second effect). We also note that in our view HCA has been inconsistent in that it emphasizes the first effect when it uses the presence of investments in central London to argue that the market is competitive (paragraphs 6.389 to 6.391) but it emphasizes the second effect when it argues that a divestiture remedy would harm incentives to invest.<sup>520</sup>
- 6.422 We note that a further effect of competition on quality, which is the flip side of the first effect above, is that in a highly competitive market firms may choose different levels of quality to differentiate themselves in order to avoid competing closely. In such a case, low-quality firms may be discouraged to invest as catching up implies fierce competition and, as a result, high-quality firms will not find it necessary to invest in response in order to maintain a quality differential.<sup>521</sup> We note, however, that, as discussed above, the opposite appears to be the case in central London, where a number of hospital operators appear to have invested and positioned themselves on the high-acuity end of the market and are regarded as having a strong reputation (see paragraphs 6.411 and 6.412, and 6.414 to 6.417). This case is known in the literature cited by HCA as a levelled market,<sup>522</sup> in which the ‘escape-competition effect’ dominates and there is a positive relationship between competition and investment.<sup>523</sup>
- 6.423 We now consider HCA’s further point in relation to competition and quality, namely that if patients have little choice but to attend the hospital chosen by a healthcare buyer which requires the lowest procurement price subject to a minimum quality standard, there is an incentive for hospitals to cut cost and unobservable aspects of quality (see paragraph 6.398). It is not clear to us that the assumptions underlying

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<sup>519</sup> Aghion, P, Bloom, N, Blundell, R, Griffith, R, & Howitt, P (2005), ‘Competition and Innovation: An Inverted-U Relationship’, *The Quarterly Journal of Economics*, 120(2), 701–728.

<sup>520</sup> See [HCA supplemental submission](#), paragraph 1.8.

<sup>521</sup> This effect is illustrated in the context of a large number of duopolies, product market competition and innovation in Aghion et al (2005).

<sup>522</sup> See Aghion et al (2005).

<sup>523</sup> We note that, while competition is positively related to investment in a levelled market, the market is more likely to be levelled when competitive pressures are insufficient for firms to seek to differentiate by investing in quality.



this statement apply to this case. We note that, within the network of hospitals included in patients' private medical policies, the choice regarding the hospital at which patients are to be treated is often made, not by the PMI, but by the patient and/or the GP and/or the consultant. We further note that the views expressed by HCA do not suggest that HCA (as well as its closest competitors) has been forced by PMIs to cut prices subject to a minimum quality standard. In particular, HCA told us that: (a) patients' (and GPs') greater focus was on quality, particularly in London (consistent with the CC survey results); and given that, (b) HCA made a number of investments in quality also with a view to attracting the best consultants (and therefore patients). We finally note that, to the extent that (a) HCA is subject to a strong reputational effect, as HCA contended (see paragraph 6.402);<sup>524</sup> (b) restricted networks exist (see paragraph 6.426) and (c) our informational remedies are implemented, any negative effect of competition on unobservable aspects of quality is likely to be greatly reduced.

6.424 In relation to the empirical studies cited by HCA as examples of competition leading to lower quality, in particular for unobservable aspects of quality (see paragraph 6.399), we note that there are other examples of empirical research that suggest that competition increases quality.<sup>525</sup> In addition, as discussed in paragraphs 6.420 to 6.422, we consider that the evidence from the market at hand suggests that competition leads to quality improvements. We reiterate that this is also consistent with HCA's view that a 'competitive dynamic' leads to 'innovations in the market and new investment to stay ahead of competitors'.<sup>526</sup>

- *PMIs' incentives in relation to quality*

6.425 HCA expressed a concern that PMIs had an incentive to cut costs by resisting quality improvements or an expansion of the range of services offered to policyholders (see paragraph 6.401). HCA appears to suggest that, for example, PMIs may find it profitable not to recognize in their networks 'high-quality-high-cost operators', as this would cut claim costs more than it would increase the revenue from higher premiums/additional policyholders. If this was the case, HCA would appear to suggest that this would weaken high-quality-high-cost operators relative to low-quality-low-cost operators and would presumably lead to a reduction of the quality offered on average in the market. We make the following observations in this respect. HCA appears to base its view on the assumption that, at the point of purchasing a private medical policy, customers are more interested in price and hospital location than in quality and range (as opposed to the patients' focus at the point of treatment). HCA did not provide any evidence to support this view. As we have not investigated preferences for healthcare insurance policies at the point of purchasing, we have not seen evidence to support this view.<sup>527</sup> However, we note that, in the case of central London, evidence from PMIs suggests that their customers, and in particular corporate customers, want to retain access to (a subset of) central London hospitals (see Appendix 6.10, Annex A, paragraphs 41 to 49). This in fact corresponds to a choice for high reputation hospitals and, as a result, PMIs have to provide such policies. As discussed in paragraph 6.423, in addition we point out that, to the extent that hospital operators' investments are a response to demand for quality and range

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<sup>524</sup> [HCA response to provisional decision on remedies](#).

<sup>525</sup> As Gaynor (Chief Econ at the FTC) points out in his summary of the research in this field, 'What do we know about competition and quality in healthcare markets?', the result that mortality increases with the number of competitors contrasts with studies in the USA.

<sup>526</sup> [HCA response to provisional findings](#), paragraph 3.51.

<sup>527</sup> As we investigated patients' preferences for healthcare treatments and not their preferences for healthcare insurance policies, we did not investigate PMIs' customer preferences in relation to price, hospital location and quality and range at the time they were buying their policy.

(from patients and/ or consultants), as HCA claimed, it is difficult for PMIs to prevent many of their customers from going to hospitals which are perceived to offer a higher quality or a wider range. Instead, we consider it likely that PMIs will increasingly use restricted networks in order to give their customers the choice to pay more for an insurance product that includes access to high-cost (and presumably high-quality) hospitals.

- 6.426 Regarding HCA's view that 'restricted' networks are likely to increase PMI bargaining power (see paragraph 6.403), we note the following points. In general, we agree with HCA that restricted networks that exclude HCA hospitals from the network can be expected in a well-functioning market. In particular, it is beneficial for PMI customers to have the choice between lower-premium and higher-premium insurance policies giving access to less or more inclusive sets of hospitals respectively. However, we do not consider that the presence of restricted networks necessarily strengthens PMIs' bargaining power against HCA. This depends on the strength of PMIs' outside options in a hypothetical negotiation with HCA for the 'unrestricted network'. PMIs' outside options are improved by the presence of restricted networks to the extent that there is enough demand for these networks (ie the PMI knows that it can divert a significant portion of its customer base away from HCA). In this respect, we note that there is a core set of customers (eg corporate customers) in central London that want HCA's hospitals in their policy network. These customers would not switch to a number of HCA's rival hospitals with/without low premium policies.

### *The rest of the UK (outside central London)*

#### *Parties' views*

- 6.427 On the whole, BMI, Spire, Nuffield and Ramsay did not make extensive submissions regarding quality and range.
- 6.428 [redacted]<sup>528</sup> BMI noted 'the importance of quality to the decision making of patients and consultants'.<sup>529</sup>
- 6.429 Spire stated in reference to the development of private healthcare outside London that:

PHPs have invested significantly to provide patients with a range of services that is superior to that offered by their competitors. Private operators have invested significantly to increase the availability of services such as MRI scanning and radiotherapy, provision of which is significantly below the OECD average across the UK public and private sectors. In addition, patients have traditionally been required to travel to London to access most complex surgery in a private hospital setting, but Spire has invested to significantly develop the private offering of complex surgery outside London.<sup>530</sup>

- 6.430 Spire mentioned its 'substantial and sustained investment in facilities and services in direct response to development by local rivals' and cited investments to upgrade diagnostic equipment and its endoscopy suite in response to development of Nuffield's Chesterfield Hospital in Bristol, investments in paediatrics in response to Nuffield Leeds and the development of a theatre [redacted].<sup>531</sup> Spire further mentioned its

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<sup>528</sup> BMI response to provisional findings, paragraph 2.4.3.

<sup>529</sup> *ibid*, paragraph 6.1(c).

<sup>530</sup> Spire response to provisional findings, paragraph 1.8.

<sup>531</sup> *ibid*, paragraph 1.16.

‘maintaining superior efficiency and quality over time’<sup>532</sup> as a likely explanation of its profits.

- 6.431 Spire acknowledged in its internal documents that its ‘quality/investment story has been well received but failed to differentiate us from the competition’ and that ‘the key issue is differentiation for GP’s, patients and corporates such as they are willing to insist on/pay a premium for Spire. All the evidence we have gathered to date suggests we are now well respected but not differentiated’.
- 6.432 Spire further stated that its ‘improved economic profitability is a function of increased efficiency and competitive success’ and that ‘the CC is seeking to penalise Spire for seeking to compete for business, improve patient choice and deliver its services more efficiently ... the CC is likely to damage the competitiveness of the industry, reduce incentives to invest and raise costs to private and NHS patients’.<sup>533</sup>

#### *Our assessment*

- 6.433 In relation to range, we note that the evidence suggests that hospital operators such as Spire and BMI are striving to increase their product range at some of their hospitals, in particular with respect to high-acuity services which were previously offered exclusively by the NHS. We note that none of BMI, Spire, Nuffield and Ramsay argued that they were, at an operator level, differentiated in terms of range. We consider hospital characteristics, including range of specialties and provision of critical care, in our local assessments of individual hospitals.
- 6.434 We have some evidence that increases in the level of competition at the local level have given rise to competitive responses in terms of investments in range and equipment:
- (a) BMI responded to Circle’s entry in Bath by increasing its investments in new equipment.<sup>534</sup>
  - (b) While TEC did not consider that it was large enough for its entry in Edinburgh to prompt more than a ‘limited competitive reaction’ from Spire, Spire claimed that its investments in new optometry equipment were a competitive response to TEC.<sup>535</sup>
  - (c) BMI responded to Circle’s entry in Birmingham by refurbishments and the establishment of a dedicated eye centre at its Priory Hospital.
  - (d) Spire invested in a new modular theatre and CT scanner in response to Circle’s plans to enter in Edinburgh.<sup>536</sup>
- 6.435 In relation to quality, we note that none of BMI, Spire, Nuffield and Ramsay argued that they were, at an operator level, differentiated in terms of quality. As noted above, Spire, [X], acknowledged in its internal documents that its ‘quality/investment story has been well received but failed to differentiate us from the competition’.
- 6.436 We also note that the evidence available to us did not suggest that PMIs, when negotiating, materially differentiate between the hospital operators in terms of quality

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<sup>532</sup> *ibid*, paragraph 5.3.

<sup>533</sup> *ibid*, paragraphs 5.43 & 5.44.

<sup>534</sup> [Provisional findings report](#), Appendix 6.1, pp17 & 18.

<sup>535</sup> Appendix 6.3, paragraphs 66 & 67.

<sup>536</sup> Appendix 6.3, paragraph 44.

(at the operator level, although we note that differences in quality between hospitals at the local level may exist).

- 6.437 As for central London, because of a lack of objectively comparable quantitative data we have not been able to measure quality indicators, including clinical outcomes in order to compare the various hospital operators.
- 6.438 Overall, in relation to product range, we considered that the evidence available does not suggest that BMI, Spire, Nuffield and Ramsay are substantially differentiated from each other at an operator level, although differentiation may exist at a hospital level. Similarly to central London, in relation to quality the evidence available to us did not lead us to conclude that BMI, Spire, Nuffield and Ramsay were differentiated in terms of quality at the operator level.
- 6.439 We consider, based on our observations of increases in competition leading to increases in quality, that investments in quality and range can be expected to be enhanced in a more competitive market.

### *Conclusions on quality and range*

- 6.440 We found that, both within and outside central London, there is no evidence of material quality differences between hospital operators, but we note that the lack of objectively comparable measures of quality makes quality difficult to assess (see paragraphs 6.386, 6.412, 6.418 and 6.437). We also found that, notwithstanding the weak competitive constraints and barriers to entry and expansion, there is a degree of competition over both quality and range in many local areas, including central London (see paragraphs 6.406(a), 6.421 and 6.434). The evidence indicates that overall, quality and range will not worsen with greater rivalry and we have reason to believe that they will improve in more competitive markets (see paragraphs 6.421, 6.422 and 6.434). For the reasons set out in paragraphs 6.386 and 6.387, we have not found an AEC in relation to quality and/or range. The remedies that we are putting in place to address the AECs we have identified in relation to hospital prices are expected to increase competition which we consider will improve price as well as quality and range. The remedies we are putting in place to address the AEC we have identified in relation to hospital performance information are expected to increase the information available to patients and GPs and hence to contribute to their ability to make choices on the basis of both quality and price.

## ***Profitability***

### *Introduction*

- 6.441 An important indicator of the extent of competition in a market is the level of profits of the firms involved. A competitive market is likely to generate significant variations in profit levels between firms as supply and demand conditions change, but with an overall tendency towards levels commensurate with the cost of capital of those firms. At particular points in time, the profits of some firms may exceed what might be termed the 'normal' level. Reasons for this could include, for instance, cyclical factors, transitory price or other initiatives, the fact that some firms may be more efficient than others and the fact that some firms may be earning profits gained as a result of past innovation. However, competition should put pressure on profit levels, so that they move towards the cost of capital in the medium to long run. A situation where profits are persistently above the cost of capital for firms that represent a substantial part of the market could be an indication of limitations in the competitive process.

6.442 We have assessed the profitability of the private hospital operators in accordance with the principles set out in our Guidelines.<sup>537</sup> These Guidelines highlight three key elements of our approach to profitability analysis:

- (a) we compare the returns made by firms against their cost of capital, as estimated using the capital asset pricing model (CAPM);<sup>538</sup>
- (b) we are concerned to understand whether firms representing a *substantial* proportion of the market are making returns which are *persistently* in excess of their cost of capital;<sup>539</sup> and
- (c) we are concerned with economic rather than accounting measures of profit and may, therefore, make adjustments to the financial information of the firms being analysed in order to identify economic profits.<sup>540</sup>

6.443 Our approach to analysing the returns made by the private hospital operators is set out in detail in Appendix 6.13, and our assessment of their cost of capital is detailed in Appendix 6.14.

### *Our approach to the profitability assessment*

6.444 We have conducted an assessment of the profitability of the seven largest private hospital operators in the UK (the relevant firms).<sup>541</sup> These firms account for 74 per cent of the market for privately-funded acute healthcare in the UK.<sup>542</sup> The rest of the market is accounted for by a large number of smaller and specialist operators, as well as NHS PPUs.<sup>543</sup>

6.445 We have assessed the financial performance of the private hospital operations of each of the relevant firms, without seeking to exclude the revenues and costs generated from either their publicly-funded activities or services such as cosmetic surgery, mental health, fertility or maternity care.<sup>544</sup> This approach was adopted to avoid making potentially arbitrary allocations of costs among the various revenue streams of the businesses.<sup>545</sup> We did, on the other hand, exclude all activities that were not carried out within the firms' acute private hospitals, including fitness centres, primary care facilities, ISTCs and separate facilities specializing in cosmetic and IVF treatments.

6.446 Our analysis is based on the financial performance of the relevant firms over the five financial years ending between January 2007 and June 2012. We consider that a five-year period is sufficiently long for us to evaluate the persistence of profitability, although we have taken into account both the likely impact of the recession and the growth in NHS demand on the profits of the relevant firms over the period. Moreover, we note that changes in the structure of the market mean that the financial performance of the sector prior to 2007 is unlikely to be a relevant indicator of the current competitive conditions in the market.

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<sup>537</sup> [www.competition-commission.org.uk/assets/competitioncommission/docs/2013/publications/cc3\\_revised\\_.pdf](http://www.competition-commission.org.uk/assets/competitioncommission/docs/2013/publications/cc3_revised_.pdf).

<sup>538</sup> CC3, Annex A, paragraph 16.

<sup>539</sup> CC3, paragraphs 116-119.

<sup>540</sup> CC3, paragraph 115.

<sup>541</sup> These firms are: Bupa Cromwell Hospital (BCH), General Healthcare Group (BMI), HCA, Nuffield, Ramsay, Spire and TLC.

<sup>542</sup> Laing & Buisson, 2012.

<sup>543</sup> All of these smaller operators have market shares of less than 2 per cent.

<sup>544</sup> This approach included NHS PPUs and pay beds within the relevant market, although no NHS trust had large enough private revenues to be included as one of the relevant firms.

<sup>545</sup> These revenues are generated using the same assets.

- 6.447 We used the return on capital employed (ROCE) approach to assess the profitability of the relevant firms, making a number of adjustments to their financial statements in order to ensure that our analysis was economically meaningful.
- 6.448 Most of the relevant firms raised no concern with our use of a return on capital approach. Spire suggested that rather than adopting the ROCE approach, we should assess profitability using the IRR on the grounds that 'internal rate of return (IRR) and Net Present Value (NPV) are conceptually the correct methods for measuring profitability because they take into account the cash inflows and outflows of a business activity (rather than accounting revenues and costs, which include accruals and non-cash items)'.<sup>546</sup> While we agree that conceptually the IRR is an appropriate method of measuring the profitability of a given project, we believe that the approach we have adopted in estimating the ROCE not only closely approximates to the IRR methodology, but also has the advantage of avoiding the difficulties inherent in identifying the cash flows of a given activity within a broader business, and is thus a more appropriate measure in the current case. For example, Ramsay and Spire told us that they were unable to separate out the cash flows of their private hospitals from those of their other activities, while HCA told us that it did not track cash flow at the UK level with its cash flows consolidated into its parent company's accounts. In the absence of detailed cash flow information, it is not possible to conduct an accurate IRR analysis.

#### *Adjustments to the relevant firms' accounting information*

- 6.449 As set out in our Guidelines, in a competition investigation we are interested in understanding the economic rather than accounting profitability of firms. Economic costs are the costs of resources used at a price at which they would be traded in a highly competitive market, where entry to and exit from the market is easy. The value of resources consumed and assets used should reflect their current value to the business.<sup>547</sup>
- 6.450 We based our assessment on the relevant firms' accounting profit as set out in their financial statements, but with certain adjustments. There were no significant issues in identifying the relevant revenue streams and, on the whole, we accepted the firms' own cost allocation methods in allocating corporate overhead costs to their private hospital businesses. Therefore, we made few adjustments to the profit and loss data submitted to us by the relevant firms, with a notable exception being to the depreciation charge on buildings to ensure consistency with the value of capital used in our analysis.
- 6.451 Under the approach set out in our Guidelines, the value at which assets are capitalized should reflect their current value to the business, which is the loss the entity would suffer if it were deprived of the asset involved. The method of determining the value to the business of an asset is set out in Figure 6.5.
- 6.452 Where an entity is putting an asset to profitable use, the deprival value of the asset will be equal to its replacement cost. Similarly, the (depreciated) replacement cost of an asset represents the investment that a new entrant would need to make in order to provide a service of the same quality as an incumbent operator.

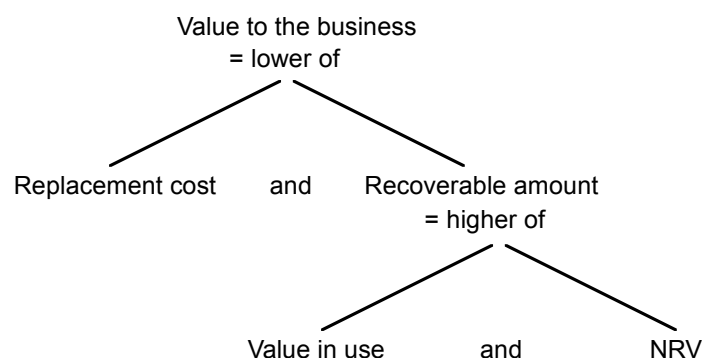
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<sup>546</sup> BMI also raised this point.

<sup>547</sup> Income should also be included at its economic level. This will generally be the case where all sales and costs of inputs are recorded at arm's length or market values.

FIGURE 6.5

## Establishing which valuation basis for an asset gives its value to the business



Source: UK Accounting Standards Board, Statement of Principles (1999).

- 6.453 There are two main types of adjustments that can be made to balance sheets of businesses in a competitive assessment. The first adjustment is to the assets and liabilities that are recognized in the capital of the business. In our analysis, we made some adjustments to the intangible assets recognized. The second is to the value which is attributed to both tangible and intangible assets and liabilities. We made a number of substantial adjustments to the value at which tangible assets were recognized in the capital base of the relevant firms.
- 6.454 In some cases, our estimates of the capital employed by the relevant firms were significantly above those of the firms themselves due to the revaluation of land and buildings to replacement cost, rather than historic cost.<sup>548</sup> In other cases, our estimates of the capital employed were substantially below those of the firms themselves due to the exclusion of the large majority of purchased goodwill and a downward revision to the carrying values of land and buildings.<sup>549</sup> As a result, in these cases our estimates of the ROCE of the relevant firms were significantly higher than the return on investment earned by the owners of the firms. However, in the context of a competitive assessment, we are concerned with understanding whether specific operational assets are able to earn a return in excess of the cost of capital for those assets, rather than identifying whether specific owners or investors are earning such a return. Indeed, we would expect that, where there is an active market for firms, the price at which they are exchanged should allow the purchaser to earn a normal return on their investment even if the underlying return on the assets is above or below this level as the price would adjust accordingly. In the longer run, a return in excess of the cost of capital can only be earned on the assets employed if there are barriers to entry, while a return below the cost of capital would result in assets exiting the industry (unless there are barriers to exit).

### *Recognition of intangible assets*

- 6.455 The principal intangible asset recognized on the balance sheets of some of the relevant firms was purchased goodwill.<sup>550</sup> For some of the relevant firms, notably BMI

<sup>548</sup> For example, our analysis increased the value of Nuffield's land and buildings by approximately one-third.

<sup>549</sup> Although, in other cases, we have revised upwards the carrying value of land and/or buildings.

<sup>550</sup> BMI, Spire, Ramsay and HCA all had purchased goodwill recorded on their balance sheets due, largely, to changes of control of the businesses and/or subsequent business acquisitions.



and Spire, this balance was substantial.<sup>551</sup> Goodwill reflects the difference between the price paid for the business on acquisition and the value of the separately identified fixed assets, both tangible and intangible, recorded on the balance sheet. Businesses are generally acquired on the basis of their (sustainable) earnings or profits rather than the value of the assets they employ. Hence, purchased goodwill is generally composed of two elements: the first is the value of intangible assets that were not separately identified on acquisition, while the second is the value of expected future economic profits of the business. For profitability analysis, we wish to identify and apply a value to the former but exclude the latter since the purpose of our analysis is to quantify the profits of the relevant firms. Hence, our approach was to identify and value intangible assets according to the criteria set out in our Guidelines.<sup>552</sup> The remaining goodwill on the firms' balance sheets was excluded from capital employed in our analysis.

- 6.456 We reviewed the relevant firms' submissions regarding a range of potential intangible assets, including staff training and development, IT systems, regulatory approvals, a reputation for providing high-quality service, relationships with patients, GPs and consultants and clinical and administrative processes and procedures. We determined that the main category of intangible assets held by the businesses that should be capitalized in our analysis were IT systems. We considered that many of the other categories of intangibles proposed by the relevant firms did not represent expenditure that was additional to that necessarily incurred in running their businesses, or separable from the business. However, we took into account in our qualitative assessment the fact that an operational business incurs some additional costs during a start-up phase—over and above the cost of replacing the tangible and current assets—and that our estimates of ROCE will be (slightly) overstated by not quantifying these in our analysis. As discussed in paragraph 6.472, we do not believe that this overstatement would have a material impact on our findings.

### *Valuation of assets*

- 6.457 The main categories of fixed assets recorded on the balance sheets of the relevant firms were land, buildings and equipment. The carrying value of these assets had been determined either with reference to the historic cost of acquiring the asset, or at a market value at a certain date as the result of a fair value adjustment (on acquisition) or revaluation of the asset to support a refinancing transaction.

### *Equipment*

- 6.458 In light of the relatively short useful economic life (UEL) of the equipment, which was generally less than ten years, we considered that the carrying value of these assets in the accounts of the relevant firms were likely to be a reasonable approximation of their economic value. BMI, Ramsay and Spire highlighted the issue of assets that were fully depreciated in their accounts but still in use and which, using this approach, would be undervalued. We noted this issue and, although we did not consider that it was likely to be material, we have taken it into account in our qualitative assessment.<sup>553</sup>

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<sup>551</sup> However, as of September 2012, the consolidated GHG's goodwill was written down by £811 million, following an impairment review.

<sup>552</sup> CC3, [Annex A](#), paragraph 13.

<sup>553</sup> We considered that we did not have sufficient information to make quantitative adjustments to rectify this issue.



## *Land and building*

- 6.459 For land and buildings, which had very long UELs, we thought that the historic cost was likely to significantly understate the current economic cost (or depreciated replacement cost) due to inflation and changing real prices over the period since the asset had been acquired. On the other hand, where the carrying values of land and buildings were determined as part of a revaluation, we considered that their value may be overstated according to the principles set out in Figure 6.5. These carrying values had been determined with reference to the market values of the hospitals,<sup>554</sup> which were based on the level of profits generated by the private hospital business and the multiples<sup>555</sup> that real estate investors were prepared to pay for private hospitals at the date of valuation. We considered that these valuations were circular from the point of view of profitability analysis as the profits of the business determined the value of the asset, which would then be used, in turn, to examine profitability. We did not consider, therefore, that they provided a reliable value for land and buildings in the context of our analysis.
- 6.460 The approach that we took was to gather information on the costs of replacing the hospital assets owned by the relevant firms, ie the costs of acquiring the plots of land and constructing the buildings. This approach is consistent with our Guidelines, which highlight that we consider the 'replacement cost' or 'Modern Equivalent Asset value' (MEA) to be the economically meaningful measure.<sup>556</sup> The main sources of information we relied on were a DTZ report on land prices (see Appendix 6.15) that we commissioned for the purposes of this assessment, the relevant firms' reinstatement cost estimates for their buildings, and the costs incurred by private healthcare providers in building new hospitals in the last few years.<sup>557</sup> We also conducted a number of sensitivities on our analysis based on information and reports submitted by the relevant firms where these contained asset values that were different from those used in our 'base case' and where we considered that there was uncertainty over the correct level or approach to estimating the replacement cost of an asset. A fuller discussion of our approach to assessing the replacement cost of land and buildings is set out in Appendices 6.16 and 6.17 respectively.

## *Relevant firms' views on our approach to valuing assets*

- 6.461 BMI argued that where there was 'significant uncertainty, or where adjustments to MEA values lead to questionable results' we should 'place more emphasis on values which are known with certainty (ie book values)'.<sup>558</sup> We do not agree with BMI that either one of the reinstatement values or the market values of the relevant firms' assets, which form the basis of the accounting book values, is more certain than the other. These valuations were prepared on different bases and, for the purposes of our analysis, we consider that the reinstatement cost is appropriate and the market value is not due to the potential for capitalizing excess profits in the value of the capital employed. Hence, we have used the former.
- 6.462 Ramsay made a similar argument with respect to intangible assets, noting that 'Ramsay's preferred approach to the valuation of intangible assets is to calculate the

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<sup>554</sup> These values were estimated by surveyors.

<sup>555</sup> A multiple refers to the scaling factor applied to the profits of a business to reach the price that a purchaser will pay for that business. For example, if a business generates £10 million per year and an investor is prepared to pay £100 million for it, the multiple is ten times. Multiples reflect a number of factors, including expectations regarding the level of profits in the future.

<sup>556</sup> CC3, [Annex A](#), paragraph 14. The MEA value is the cost of replacing an old asset with a new one with the same service capability allowing for any differences both in the quality of output and in operating costs.

<sup>557</sup> The reinstatement estimates were prepared for the firms by surveyors and formed the basis of the relevant firms' insurance policies.

<sup>558</sup> [BMI response to the Profitability working paper](#).

total value of the business based on discounted future cash flows'. As in the case of tangible assets, we do not agree that this approach is suitable for the purposes of our analysis due to circularity. Hence, we adopted a cost-based approach to valuing intangible assets.

- 6.463 The other private hospital operators generally did not disagree with the replacement cost approach; although several made submissions regarding how replacement costs should be measured. We took these submissions into account and made adjustments to our approach as necessary, including applying a number of sensitivities to our estimates of ROCE.

### *Profitability analysis*

- 6.464 Table 6.3 shows the ROCE of each of the relevant firms, together with the weighted average ROCE for all these firms combined.

TABLE 6.3 Profitability analysis, ROCE of relevant firms

	FY07	FY08	FY09	FY10	FY11	FY12
<i>BCH</i>						
EBIT		[X]	[X]	[X]	[X]	
Capital employed		[X]	[X]	[X]	[X]	
ROCE (%)		[X]	[X]	[X]	[X]	
<i>BMI</i>						
EBIT	[X]	[X]	[X]	[X]	[X]	
Capital employed	[X]	[X]	[X]	[X]	[X]	
ROCE (%)	[X]	[X]	[X]	[X]	[X]	
<i>HCA</i>						
EBIT	[X]	[X]	[X]	[X]	[X]	
Capital employed	[X]	[X]	[X]	[X]	[X]	
ROCE (%)	[X]	[X]	[X]	[X]	[X]	
<i>Nuffield</i>						
EBIT	[X]	[X]	[X]	[X]	[X]	
Capital employed	[X]	[X]	[X]	[X]	[X]	
ROCE (%)	[X]	[X]	[X]	[X]	[X]	
<i>Ramsay</i>						
EBIT		[X]	[X]	[X]	[X]	[X]
Capital employed		[X]	[X]	[X]	[X]	[X]
ROCE (%)		[X]	[X]	[X]	[X]	[X]
<i>Spire</i>						
EBIT	[X]	[X]	[X]	[X]	[X]	
Capital employed	[X]	[X]	[X]	[X]	[X]	
ROCE (%)	[X]	[X]	[X]	[X]	[X]	
<i>TLC</i>						
EBIT	[X]	[X]	[X]	[X]	[X]	
Capital employed	[X]	[X]	[X]	[X]	[X]	
ROCE (%)	[X]	[X]	[X]	[X]	[X]	
Weighted average ROCE†	12.2	14.0	15.4	17.0	17.1	

Source: CC analysis.

\*This is calculated on an annual basis (ie the capital employed has been grossed up to 1.5 times the year-end level to take into account the fact that the EBIT relates to an 18-month rather than 12-month period).

†The weighted average ROCE includes Ramsay's results for each year in the previous financial year. For example, Ramsay's results for FY09 are added in to the FY08 average. This is because Ramsay has a 30 June year-end and hence falls between the two calendar years.

- 6.465 This analysis indicates that the profitability of the industry has improved over the period from 12.2 per cent in FY07 to 17.1 per cent in FY11, with a weighted average of 15.2 per cent for the period as a whole.

- 6.466 We estimated a range for the nominal pre-tax cost of capital for a typical stand-alone UK private hospital operator of between 7.2 and 10.5 per cent, with a midpoint estimate of 8.8 per cent. More detail on our calculations of the cost of capital, including the relevant firms' views on our approach and our response to them, is in Appendix 6.14.
- 6.467 Our assessment of the ROCE of the relevant firms indicates that BMI, HCA and Spire have persistently made profits in excess of their cost of capital.<sup>559</sup> In addition, Ramsay has demonstrated a significant increase in profitability over the period, moving from a position of making profits that were less than its cost of capital to generating returns in excess of that level. Nuffield has persistently made returns below its cost of capital, whilst BCH and TLC are making returns that are around their cost of capital on average.
- 6.468 We considered whether the firms making returns above the cost of capital represented a substantial part of the market. BMI, HCA and Spire together comprise 53 per cent of the market for privately-funded healthcare in the UK, with Ramsay accounting for an additional 5 per cent.
- 6.469 We considered how the existence of and growth in NHS revenues may have affected the profitability of the relevant firms. As set out in Section 2: Industry background, four of the relevant firms (BMI, Nuffield, Ramsay and Spire) have experienced significant increases in the volume of NHS work undertaken over the period.<sup>560</sup> As of FY11, BMI, Spire and Nuffield generated around 25 per cent of their revenues from treating NHS patients, while Ramsay generated almost half its revenues from NHS patients. To the extent that NHS revenues generate lower margins than private revenues,<sup>561</sup> we considered that our estimate of ROCE may understate that earned on the provision of services to private patients. We thought that the growth in NHS revenue over the period was likely to have allowed BMI, Nuffield, Ramsay and Spire to improve their capacity utilization. However, to the extent that this effect has supported profitability in excess of the cost of capital, we note that it relies on the prices charged to private patients not falling in response to the lower unit costs<sup>562</sup> that result from the higher volume of patients treated.
- 6.470 The results of our analysis are robust to the inclusion of relatively large sensitivities on the value of land and buildings.

### *Conclusions on profitability*

- 6.471 The assessment of profitability in competition investigations will necessarily require some estimation and reliance on assumptions. In this case we have used accounting information but made a number of adjustments to the values of capital employed to reflect economic rather than accounting costs. We have relied on a range of information on the replacement cost of assets, including accounting records, external reports on land values, surveyors' estimates of building reinstatement/replacement costs and the Valuation Office Agency's estimates of building obsolescence. We have applied a range of sensitivities to our results and these do not change our findings.

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<sup>559</sup> See Appendix 6.14 for our assessment of the cost of capital.

<sup>560</sup> HCA, BCH and TLC do a negligible quantity of NHS work.

<sup>561</sup> BMI (in its [response to the annotated issues statement](#)) and Nuffield (in its response to the financial questionnaire) told the CC that this was the case.

<sup>562</sup> The high-fixed-cost nature of the industry means that an increase in the volume of patients should result in a decline in the unit cost of treating each patient.

- 6.472 We considered whether the lack of quantification of start-up costs and fully depreciated assets in our analysis could result in the material misstatement of the level of returns being earned by the relevant firms. We concluded that if these could be quantified, it is likely that they would reduce our ROCE estimates, although not to the extent that they would substantially reduce the gap between the ROCE of the relevant firms and their cost of capital. Moreover, we considered that our approach was also likely to have overstated capital employed to the extent that no adjustments were made to reflect the low levels of capacity utilization in the industry, and hence our ROCE estimates were likely to be understated in this respect. Overall, we believe that our estimates provide a reasonable approximation of the returns being earned by the relevant firms.
- 6.473 We also note that our analysis has been conducted over a period during which the UK economy has suffered a severe recession. The evidence indicates that in spite of the recession, expenditure on privately-funded healthcare services increased over the relevant period. It seems probable, therefore, that under more normal economic conditions the relevant firms would have earned higher revenues and therefore higher profits than they did between 2007 and 2012.
- 6.474 From our analysis, we conclude that BMI, HCA and Spire have, during the period under review, been earning returns substantially and persistently in excess of the cost of capital. Ramsay has also earned returns in excess of the cost of capital in the last three years of the period, although not in the first two and a half years. As a result, we consider that there is insufficient evidence to reach a conclusion as to whether Ramsay is able to earn returns that are persistently in excess of its cost of capital. In this respect we note that Ramsay has experienced a particularly large increase in the revenues generated from providing services to the NHS, and this may be obscuring the returns earned on private patients both over the relevant period and in the longer run. We consider that the growth in NHS revenues is significantly less likely to have distorted the results of BMI and Spire due to their lower proportion of NHS revenues and the greater persistence of their excess profits.<sup>563</sup>
- 6.475 We consider that the fact that firms<sup>564</sup> that together account for between 53 and 58 per cent of the market are making returns that are substantially and persistently in excess of the cost of capital indicates that there are some limitations in the competitive process.
- 6.476 In particular, our finding of excess profitability suggests that the price of private healthcare services may be high in relation to the costs incurred by private hospital operators in providing those services, and thus higher than we would expect to find in a competitive market. We consider more evidence on the level of prices in paragraphs 6.256 to 6.383, and set out our estimates of the level of consumer detriment caused by these high prices in Section 10.
- 6.477 In addition, we consider that the difference between the replacement cost of the assets employed by the relevant firms and the market value of those same assets and, indeed, of the relevant firms as a whole, indicates that there are likely to be significant barriers to entry in the private hospital sector.

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<sup>563</sup> HCA is unaffected by changes in NHS demand as it does a negligible quantity of NHS work.

<sup>564</sup> HCA, BMI and Spire account for 53 per cent of the market between them. Ramsay accounts for an additional 5 per cent of the market.

## **Findings**

- 6.478 We have examined the extent to which incumbent hospital operators are constrained by the threat of entry or expansion. We concluded that barriers to entry and expansion exist. As explained in paragraph 6.477, our profitability analysis also indicated that there are likely to be significant barriers to entry in the private hospital sector.
- 6.479 We found that in all local areas including in central London a combination of high, sunk costs and long lead times associated with setting up a private hospital together constituted a significant barrier to entry and expansion. We also found that in central London, as well as a combination of high sunk costs and long lead times constituting a barrier to entry, the lack of availability of suitable sites from which to operate a private hospital and the difficulty in obtaining planning permission for a private hospital also constituted significant barriers to entry and expansion.
- 6.480 As set out in paragraph 6.199, we found high levels of concentration and weak competitive constraints between private hospitals including PPUs in a number of local areas across the UK. Outside central London we identified 70 private hospitals including PPUs that are subject to weak competitive constraints.
- 6.481 In central London we found that the competitive constraints currently exerted on HCA by other private hospitals including PPUs located in central London are weak. PPUs in central London, in particular, are in aggregate a weak constraint, and the future expansion of PPUs does not appear likely to change this conclusion substantively. We have also considered Greater London private hospitals including PPUs and found that these impose weak competitive constraints on HCA. We also found that the NHS, both inside and outside central London, imposes, if any, very limited competitive constraints on HCA.
- 6.482 In considering the effect on competition of the barriers to entry and expansion and the weak competitive constraints we found, we looked at price outcomes, non-price outcomes (quality and range) and profitability.
- 6.483 In relation to price outcomes, we looked at both self-pay and insured prices. With regard to self-pay prices, prices of treatments were generally set at the hospital level, thus varying across hospitals within a hospital operator's portfolio (ie prices are set at the local level). As discussed in paragraphs 6.256 to 6.275, our PCA showed that there is a causal relationship between local concentration and self-pay prices for inpatient treatments. Private hospitals in more concentrated local areas charge higher self-pay inpatient prices than hospitals in less concentrated local areas. Our review of the qualitative evidence relating to self-pay prices, which included hospital operators' views and a wide range of internal documents (see Appendix 6.9, Annex B), indicated that the behaviour of hospital operators is consistent with this result. We therefore concluded that private hospitals including PPUs, on average, currently charge higher self-pay prices for inpatient treatments in local areas where they face weak competitive constraints. For the reasons set out in paragraph 6.275, we also considered that the price-concentration relationship for some day-case and outpatient treatments will be similar to the relationship we found for inpatient treatments.
- 6.484 With regard to insured patients, prices of treatments are set in bilateral negotiations between hospital operators and PMIs, and are generally the same for all hospitals in the hospital operator's portfolio of hospitals contracted with the PMI, thus reflecting average prices of each treatment. Whilst this equally applies to HCA, HCA is slightly different from the other main hospitals groups as its hospitals are primarily located in central London. During these negotiations, discussions typically focus on the price of

the overall bundle of a hospital operator's services (ie the associated revenue), with relatively little focus on the price of individual treatments.

- 6.485 Internal documents reporting the planning of negotiations by both hospital operators and PMIs showed that the competitive position of hospitals at the local level is an important factor that both PMIs and hospital operators take into consideration in their negotiations over insured prices and therefore are consistent with the existence of a relationship between local concentration and prices negotiated between PMIs and hospital operators. Internal documents also showed that the PMIs and hospital operators are dependent upon each other and it does not appear that either side anticipates that it would survive without substantial damage in the event of a sizeable delisting of hospitals from a PMI's network. In line with this we observed that, as a result of the 2011/12 Bupa–BMI delisting, both parties appear to have suffered substantial direct damage. This suggests that both hospital operators and PMIs have some degree of bargaining power in negotiations, also depending on the strength of their outside options.
- 6.486 We conducted an empirical analysis of insured prices for inpatient and day-patient treatments. We do not have strong reasons for expecting the exclusion of outpatient treatments to materially affect our results. For this reason and taking into account the considerations set out in paragraph 6.484, we consider that the conclusions of our empirical analysis apply across the range of treatments (ie inpatient, day-case and outpatient treatments). We carried out separate analyses for central London and outside central London to take account of possible differences between these two areas (eg cost differences).
- 6.487 We found consistent results in relation to HCA and TLC in central London which supported the conclusions that HCA faces weak competitive constraints from its rivals in central London, even from its closest competitor TLC (as reflected, for example, in their respective shares of supply). In particular, we found that HCA charges significantly higher prices to PMIs than TLC. We found this to be the case on average across PMIs, and for the large majority of individual PMIs, for each year between 2007 and 2011 inclusive. Over this period, HCA charged prices to PMIs that were on average [X] per cent higher than TLC. In addition, in relation to the prices paid by PMIs relative to self-pay patients for HCA, we found that [X] paid prices that were similar to, and in a small number of cases up to [X] per cent lower than, the prices paid by self-pay patients, while [X] paid prices to HCA that are higher than the prices paid by self-pay patients on average in 2007 to 2011.
- 6.488 Notwithstanding the limitations of our empirical analysis, we found that, overall, for central London, all the results support our hypothesis that local substitutability plays a role in determining insured price outcomes and provide an indication of the magnitude of the relationship between local concentration and insured prices.
- (a) In relation to BMI, Spire, Nuffield and Ramsay outside central London, our insured price analysis results were mixed. We found that Ramsay is the lowest-price operator on average across PMIs and is also characterized by the least concentrated portfolio of hospitals relative to the other three operators. Nuffield and Spire charge broadly similar prices and are characterized by similarly concentrated portfolios of hospitals. BMI charges similar prices to Nuffield and Spire but BMI's portfolio is characterized by higher concentration than that for Spire and Nuffield.
- (b) The insurer-specific price index results, [X], were not consistent with the average price index results.

(c) [X] pays prices to the four national hospital operators which are significantly lower than the prices paid by self-pay patients on average over the period 2007 to 2011. This is also the case for [X], although to a lesser extent, and with the exception of the prices it pays to [X] generally pay prices at least as high as self-pay patients.

6.489 Notwithstanding the limitations of our empirical analysis, we found that whilst some of the results are broadly consistent with our hypothesis that local substitutability plays a role in determining insured price outcomes, other results are not.

6.490 In relation to non-price outcomes (quality and range), we found that, both within and outside central London, there was no evidence of material range and quality differences between hospital operators, but we note that the lack of objectively comparable measures of quality makes quality difficult to assess. We also found that, notwithstanding the weak competitive constraints and barriers to entry and expansion, there is a degree of competition over both quality and range in some local areas, including central London. The evidence indicates that overall, quality and range will not worsen with greater rivalry and we have reason to believe that they will improve in more competitive markets.

6.491 From our profitability analysis, we concluded that during the period under review BMI, HCA and Spire have been earning returns substantially and persistently in excess of the cost of capital. Ramsay has earned returns in excess of the cost of capital only in the last three years of the period and not in the first two and a half years. As a result, we do not consider that there is sufficient evidence to reach a conclusion that Ramsay is able to earn returns that are persistently in excess of its cost of capital. We did not find that Nuffield was earning returns substantially and persistently in excess of the cost of capital over the relevant period.

6.492 We therefore concluded that:

(a) weak competitive constraints faced by private hospitals including PPUs in a number of local areas across the UK including central London, combined with barriers to entry and expansion, lead to higher prices of inpatient treatments as well as of some day-patient and outpatient treatments for self-pay patients in these local areas; and

(b) weak competitive constraints faced by HCA in central London, combined with barriers to entry and expansion, lead to higher prices being charged by HCA to PMIs across the range of treatments for insured patients in central London.

6.493 Three of the members of the Inquiry Group considered that the evidence set out in paragraphs 6.333 to 6.376 above supported a sufficient relationship between the weak competitive constraints in many local areas outside central London (combined with barriers to entry and expansion) and insured prices. They also considered that the fact that BMI, HCA, Spire and Ramsay, which together account for approximately 53 per cent of the market, made returns that are substantially and in the case of BMI, Spire and HCA persistently in excess of the cost of capital also suggests that there are some limitations in the competitive process outside central London as well as within central London for insured patients. Such members were therefore of the view that, as in central London, the weak competitive constraints (combined with barriers to entry and expansion) lead to higher prices being charged by BMI, Spire and Nuffield to PMIs for insured patients outside central London. They did not consider that this was the position in relation to Ramsay given Ramsay's significantly lower prices and that it operates the smallest number of hospitals in local areas subject to weak competitive constraints.

- 6.494 However, the other two members of the Inquiry Group did not find that the evidence was sufficient to support such a relationship between weak competitive constraints (combined with barriers to entry and expansion) and insured prices outside central London. In particular, in their view, the insured price results were mixed across insurers and by insurer and, together with the remaining evidence, were insufficient to make a finding that local concentration outside central London, combined with barriers to entry and expansion, was leading to higher insured prices across the range of treatments outside central London.
- 6.495 Section 10 sets out the effect of this difference in the members' assessment of the evidence on our final AEC findings.



## 7. Consultants

### *Introduction*

- 7.1 This section sets out our assessment of whether there are features relating to the provision of consultant services which give rise to one or more AECs. We first consider the nature of consultant services and the issues raised by the parties. We then address whether individual consultants have local market power giving rise to one or more AECs, following which we consider whether consultant groups, in particular those that agree prices, adversely affect competition. Lastly, we consider the extent to which insurers may have buyer power in respect of consultants, which may be used to suppress consultant fees to a level below which would prevail in a competitive market and/or lead to a reduction in patients' choice of consultant, quality and innovation.

### *Nature of private consultants services and parties' views*

- 7.2 The provision of consultant services is highly fragmented and differentiated. As described in paragraphs 5.18 and 5.19, we found that each consultant specialty could be viewed as a separate product market. We also found that, as with private hospital services, the geographic market is local. We have not, however, needed to define each such local area for the purposes of our final report.
- 7.3 A number of factors suggested that some consultants and/or consultant groups may have local market power:
- (a) In some local areas, there are a limited number of consultants in private practice for particular specialties or for particular types of treatment. The number of consultants in any local area is principally driven by the requirements of the NHS as the vast majority of consultants<sup>565</sup> have an NHS consultant post. This may be due to the nature of the treatment and/or specialty;<sup>566</sup> limited demand for the particular specialty, sub-specialty or treatment making it uneconomic for a consultant to be in private practice in the local area; the nature of the local services provided at private hospitals and other private facilities which may mean that consultants are unable to practise particular specialties, sub-specialties or offer certain treatments in the area; the extent to which there is capacity for such specialties or treatments at such hospitals and facilities; and, if the patient is insured, the extent of recognition of particular consultants in the area by the patient's PMI.
  - (b) Patients are generally referred to consultants by another clinician, whether a GP or another consultant. Historical referral patterns and the fact that referrals are made for reasons other than cost (eg clinical need) may, for example, confer local market power. It may also be the case that as a patient progresses through their treatment, their ability to switch consultant reduces significantly, as patient switching costs increase and other consultants in private practice may be unwilling to take over responsibility for a patient mid-treatment.<sup>567</sup>

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<sup>565</sup> The OFT's survey by GHK in August 2011 found that only 4 per cent of consultants in private practice did not have an NHS consultant post: [www.of.gov.uk/shared\\_of/market-studies/Final-Survey-Report-08-2011.pdf](http://www.of.gov.uk/shared_of/market-studies/Final-Survey-Report-08-2011.pdf).

<sup>566</sup> There is significant variation in the number of consultants registered in different specialties, and within those specialties those who specialize in particular parts of the body or particular types of treatment. In terms of consultants willing to practise in the private sector, this will similarly vary for the same reasons.

<sup>567</sup> Bupa response to annotated issues statement, paragraph 2.69.

- (c) In relation to anaesthetists, generally the consultant carrying out the surgery selects the anaesthetist and in most instances requires the same anaesthetist for a particular theatre list.<sup>568</sup> Typically, the surgical consultant does not consider cost to be a relevant consideration in the selection of the anaesthetist and, together with historical preferences of the surgical consultant, the patient's choice of available anaesthetists in a local area may therefore be limited.<sup>569</sup>
- (d) Groups of consultants—usually those practising in the same specialty in a local area or practising at a particular hospital—may jointly set prices. This is most common in relation to anaesthetists' services but parties provided some evidence that consultants in a wide range of specialties, such as ophthalmology, are similarly forming groups and jointly negotiating or setting prices (see paragraph 7.17).
- (e) Private hospitals compete to attract those consultants who are likely to generate the most revenues for them. Whilst hospitals generally do not impose restrictions on consultants from practising at other facilities or offer exclusivity to consultants,<sup>570</sup> some private hospitals in some local areas have limited capacity in terms of, for example, the availability of consulting rooms, other outpatient facilities, particular equipment and theatre slots. This may limit the number of consultants in particular specialties or providing particular treatments in some local areas.
- (f) Consultant services are highly differentiated and in many cases highly specialized. Patients rely on the consultant as well as other clinicians such as their GP to determine their requirements. Patients frequently lack the knowledge or have limited capability to determine what treatments they may require and from whom. Some patients may also be quite vulnerable at the time of requiring treatment and, as with many professional services, are in a difficult position to assess not only what services they require but also quality and cost/value for money.<sup>571,572</sup>
- (g) Insured patients have limited or no sensitivity to price at the point of selecting their consultant and/or treatment.

7.4 Some insurers<sup>573</sup> argued that some consultants and consultant groups may have market power due to some or all of the factors above. Some of these insurers argued that these factors led to local market power and resulted in a lack of effective competition between consultants as they significantly limited the incentives on consultants to compete on price and quality.<sup>574</sup> Several insurers also said that there were no incentives on consultants to control costs,<sup>575</sup> and indeed Bupa<sup>576</sup> commented that the interests of consultants in private practice did not always align with those of their patients as some consultants were motivated by profit, with the consequent risk that consultants might not only overcharge but over-treat (undertake a higher specification of treatment) or over-diagnose (undertake more tests and consultations than are required). PruHealth considered there to be a limited understanding by

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<sup>568</sup> 71 per cent of anaesthetists in our consultant survey stated that they were appointed through the primary consultant, a further 18 per cent by the private hospital and only 1 per cent by the patient: [GP and consultant survey](#), Table D6.

<sup>569</sup> [AXA PPP response to issues statement](#), p46.

<sup>570</sup> However, some private hospital operators may impose on a small number of selected consultants some limitations on practising elsewhere. [3<] Restrictions on practising elsewhere are more common in the context of incentive schemes, which are considered in Section 8.

<sup>571</sup> [Bupa response to issues statement](#), paragraph 4.4; [Aviva response to issues statement](#), paragraph 1.2; [WPA response to issues statement](#), p1.

<sup>572</sup> Issues relating to the lack of available information and information asymmetries are covered in more detail in Section 9.

<sup>573</sup> [AXA PPP](#) and [Bupa responses to issues statement](#); [Aviva response to issues statement](#); [Bupa response to provisional findings](#), paragraphs 3.1 & 3.5; [WPA response to issues statement](#), p1.

<sup>574</sup> [Bupa response to issues statement](#), paragraph 4.24 et seq; [Bupa response to annotated issues statement](#), paragraph 2.66 et seq; [AXA PPP response to issues statement](#).

<sup>575</sup> [Bupa response to issues statement](#), paragraph 4.4; [Aviva response to issues statement](#), paragraph 1.2.

<sup>576</sup> [Bupa response to annotated issues statement](#), paragraph 4.27.

consultants on what basis fees should be calculated. It contended that consultant fees were not reflective of the cost of delivering the service, the level of technical ability, complexity, professional value and sociological value.<sup>577</sup>

- 7.5 The Association of Anaesthetists of Great Britain and Ireland (AAGBI) submitted that individual consultants or consultant groups in local areas did not have market power.<sup>578</sup> It stressed that the key problem was not consultants but the buyer power of the insurers, and in particular Bupa. This view was also reflected in the extensive submissions from individual consultants and consultant bodies, in particular in relation to the setting of consultant fees and insurers' strategies to increase their role in the choice of consultant for their policyholders. We consider in paragraphs 7.48 to 7.126 whether insurers have buyer power in respect of consultants.
- 7.6 In relation to consultant groups, some parties argued that consultants forming groups, as opposed to operating on a solus basis, were problematic from a competition and consumer choice perspective.
- 7.7 Bupa said that the issue of consultant groups was a growing concern in several specialisms. It noted that the CC had found over 100 groups in anaesthetics and around 40 Consultant Eye Surgeon Partnership (CESP) groups had emerged in ophthalmology in just ten years. It considered that consultant groups were therefore a market feature impacting choice and competition, and disagreed with the conclusions in the provisional findings that no AEC was caused by consultant groups.
- 7.8 Bupa and several other insurers<sup>579</sup> told us that some anaesthetists had formed groups that collectively set prices and shared revenue. They added that in some cases these groups accounted for a very large proportion of anaesthetic treatments in one or more hospitals. This, according to some insurers,<sup>580</sup> resulted in higher prices set by anaesthetist groups compared with independent anaesthetists, and in turn led to higher average prices set by anaesthetists.
- 7.9 On the other hand, anaesthetist groups, the Federation of Independent Practitioner Organisations (FIPO) and the AAGBI argued that consultant groups helped in delivering higher quality of service including the provision of emergency cover 24 hours a day, seven days a week, cross-dissemination of best practice and single points of contact and administration for patients.<sup>581</sup> The AAGBI said that the extreme buyer power of insurers was a particular issue for anaesthetists, who were the lowest earners in the sector.<sup>582</sup>
- 7.10 AXA PPP expressed concerns in particular about anaesthetist groups in a number of local areas in the UK—including what was said were illustrative case studies for Gloucestershire, Norwich and Bath—where it submitted that the groups in these areas were near monopolists in the supply of anaesthetic services, with no meaningful past entry and expansion by independents, or constraint posed by independents on the pricing of groups. Its concerns about dominant anaesthetist groups also arose from their practice of group-wide setting of prices—which it said must self-evidently restrict, prevent or distort competition on price—and allocation of work within the group itself, resulting in no choice or competition on quality. It considered there to be a lack of competition from independent anaesthetists primarily as a result of high

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<sup>577</sup> PruHealth response to Remedies Notice, p15.

<sup>578</sup> AAGBI response to provisional findings, p3.

<sup>579</sup> Bupa response to issues statement, paragraph 1.51; AXA PPP response to provisional findings, pp1–2; WPA response to issues statement, paragraph 37.

<sup>580</sup> Bupa response to provisional findings, paragraph 2.2; AXA PPP response to annotated issues statement, paragraph 4.1.

<sup>581</sup> AAGBI response to annotated issues statement.

<sup>582</sup> AAGBI response to provisional findings.

barriers to entry and expansion, including as a result of barriers to surgeons switching anaesthetists and capacity constraints of independent anaesthetists who were often committed to the NHS. Further details on parties' views on consultant groups are set out in Appendix 7.1, Annex A.

### **Market power of individual consultants**

- 7.11 As described in Sections 2 and 3, we did not find evidence of a shortage of consultants. There were over approximately 37,000 full-time-equivalent consultants in England, with an estimated 22,000 undertaking some element of private work in 2012.<sup>583</sup> The National Audit Office (NAO) estimated that 15,754 consultants representing around 39 per cent of the total consultant population undertook private work in 2011/12.<sup>584</sup> Estimates for 2013 indicate that the number of active consultants in private practice has remained fairly constant at around 21,000 consultants or 45 per cent of the specialist population.<sup>585</sup>
- 7.12 Whilst qualification as a consultant is a long process and varies from specialty to specialty, approximately 1,200 new doctors are made consultants each year.<sup>586</sup> The principal limitation on the number of consultants is the number of NHS consultant posts. We did not identify any significant barriers to a consultant starting in private practice. The main additional requirement is to obtain professional indemnity, the cost of which can be significant depending on the specialty. However, many consultants have small-scale private practices, suggesting that the cost of professional indemnity insurance is not a significant barrier, since even small-scale private practice appears to be viable.
- 7.13 As described in paragraph 5.29, there is spare capacity in private hospitals and we received no evidence that consultants have difficulties obtaining practising privileges at private hospitals or accessing consulting rooms or theatre slots. We did not find any evidence of arrangements between private hospital operators and consultants or consultant groups, under which consultants or consultant groups were granted any exclusivity to practise at their facilities.
- 7.14 We did not receive evidence that recognition by insurers of consultants that are newly entering or re-entering private practice is problematic, subject to such consultants agreeing to the relevant insurers' recognition criteria. We consider further below, in paragraphs 7.68 to 7.81, the key issue raised by consultants in relation to insurer recognition, namely the relatively new requirement introduced by some of the largest insurers for new consultants to agree not to charge above the relevant insurers' fee reimbursement levels.
- 7.15 No local areas were identified by the OFT in its decision to refer, or by parties as areas where individual consultants had local market power or where there were shortages of consultants in private practice due to in particular barriers to entry. We have not received any evidence to indicate that there are any issues around the quality of consultant services. Whilst some insurers expressed concern at consultant charging behaviour in general, the evidence submitted by such insurers did not indi-

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<sup>583</sup> Laing & Buisson, *Private Acute Medical Care* 2012, p153.

<sup>584</sup> NAO, Department of Health: *Managing NHS Hospital Consultants*, 6 February 2013, p21.

<sup>585</sup> Laing & Buisson, *Private Acute Medical Care* 2013, p145. A recent [BMA survey](#) of 1,319 consultants in early 2013 did not show a material change in the number of consultants in private practice in the UK between 2005 and 2013, even though the proportion of consultants in private practice has reduced from 60 to 40 per cent. This is due to an increase in the overall number of consultants.

<sup>586</sup> Laing & Buisson *Private Acute Medical Care* 2013, p144, estimated that the average annual increase in the NHS population in England alone was around 5 per cent over the period from 2003 to 2012, suggesting that many more consultants may become available for private practice.

cate significant increases in consultant charges, and indeed insurers have confirmed that their reimbursement rates have until very recently not been updated for some considerable time.<sup>587</sup> An analysis we undertook showed in many specialties a real-time decline in revenues, in particular since 2008/09, depending on specialty.<sup>588</sup> Paragraphs 7.55 to 7.92 describe in more detail the initiatives taken by insurers to constrain consultant fees including recent fee reimbursement reviews. We consider in more detail later in this section the extent of the insurers' buyer power in relation to consultants.

- 7.16 On the basis of our assessment of the evidence set out above and in Appendix 7.2, including the buyer power of the larger insurers, we do not find evidence that any local market power by individual consultants gives rise to any AECs in the provision of consultant services in any local market in the UK.

## **Consultant groups**

- 7.17 As described in paragraphs 7.6 to 7.10, a number of consultant groups were identified by parties, in particular insurers, as potentially raising competition concerns. In particular, anaesthetist groups were highlighted in the OFT's decision to refer as consultant groups whose formation may give rise to competitive harm. The referral patterns for anaesthetists are different from other consultants in that in the vast majority of cases the surgical consultant chooses the anaesthetist.<sup>589</sup> In addition to anaesthetist groups, Bupa also identified an ophthalmology group, CESP, as giving rise to competition concerns.<sup>590</sup>
- 7.18 A BMA survey of consultant members in 2011<sup>591</sup> indicated that the majority of respondents (79 per cent) operate as sole traders in the private healthcare sector. Of the remainder, roughly half said that they traded as a member of a limited liability company, one-quarter that they were a member of an equity partnership and one-quarter that they were a member of a limited liability partnership. Our survey of consultants<sup>592</sup> showed that whilst 76 per cent of consultants stated that they did not belong to a consultant grouping, anaesthetists were twice as likely to belong to a group as non-anaesthetists, with 39 per cent saying that they belonged to a group compared with 22 per cent for non-anaesthetists. According to our survey, anaesthetists were also more likely than non-anaesthetists to set their fees in relation to the group's guidelines or at levels specified by the group: 60 per cent of anaesthetists in a group set fees at the level determined by the group or set them with reference to group guidelines compared with 51 per cent of non-anaesthetists in a consultant group.<sup>593</sup>
- 7.19 We consider that there is no general presumption that the formation of consultant groups is anti-competitive. There may be a number of benefits to consumers resulting from the formation of consultant groups, as is the case in other professions. Bupa

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<sup>587</sup> The larger PMIs confirmed that their reimbursement fee schedules had not increased since the 1990s and for some procedures had decreased (this is particularly the case with Bupa's reimbursement fee schedule more recently). Bupa's analysis of average consultant earnings net of practice expenses in 2005 compared with 2010 showed that for the ten most common specialisms earnings remained robust. FIPO submitted evidence that established that consultants' income from private practice had been broadly stable or declining over the three years 2009 to 2011 whilst costs had been increasing: [FIPO response to annotated issues statement](#), paragraph 5.1; [FIPO response to provisional findings](#), p42.

<sup>588</sup> Trauma and orthopaedics was the largest specialty by revenue by a significant margin and it was the only specialty to have seen a significant increase in revenues between 2006 and 2011. However, this appeared from our initial analysis to have levelled off since 2009. See Appendix 7.2 for further details on this analysis.

<sup>589</sup> See first footnote to paragraph 7.3(c).

<sup>590</sup> [Bupa response to provisional findings](#), p14.

<sup>591</sup> BMA survey of consultant income, May 2011.

<sup>592</sup> [GP and consultant survey](#), Table E2 CC.

<sup>593</sup> *ibid*, Table E3 CC.



and AXA PPP<sup>594</sup> agreed that the formation of consultant groups did not in itself give rise to competitive harm but that the collective setting of prices, in particular by anaesthetist groups with a large local market share, inherently had an AEC and that it was not necessary for the CC to demonstrate any pricing effects to find that this lack of rivalry constituted an AEC.

- 7.20 AXA PPP was of the view that when anaesthetist groups set a common price adhered to by all members, they by definition eliminated all price competition between members within the partnership. When members of a partnership accounted for a very high share of local supply in the relevant market, this lack of price competition conferred substantial market power. While AXA PPP did not suggest that collective pricing within anaesthetist groups was analogous to a price-fixing cartel, it said that a parallel should be drawn with the approach taken under Chapter I of the Competition Act and EU law, which prohibited arrangements whose object was the prevention, restriction or distortion of competition, and did not require authorities to adduce any detailed evidence about their effects on competition. Bupa similarly told us that consultant groups had a negative impact on choice and competition at the local level. The most direct impact for patients is that groups tend to set uniform fee rates across all members. This means that if a group becomes too large within a particular local market, patients may have little choice other than to pay the group fee rate.<sup>595</sup>
- 7.21 An AEC cannot be presumed on the basis of collective fee setting even if combined with high market shares. A finding of market power giving rise to an AEC requires more than the presence of collective fee setting and the existence of high market shares.<sup>596</sup> In assessing whether there is market power, we will consider market share changes over time, market outcomes such as prices and profitability, as well as the structure of the relevant market including the nature of any barriers to entry and countervailing buyer power.
- 7.22 For the reasons set out in paragraphs 7.17 and 7.18 above, we focused our analysis of consultant groups on anaesthetist groups and in particular anaesthetist groups which set fees. The purpose of our analysis was to identify whether the formation of anaesthetist groups in local areas, which set fees, gave rise to widespread competition harm giving rise to an AEC. We considered that a pricing analysis of the impact of anaesthetist groups on prices would be an appropriate starting point to ascertain whether there was such widespread competitive harm. As set out in our guidelines, prices can provide evidence of how a market is functioning and importantly the extent of and nature of competition in the market.<sup>597</sup> The following section summarizes our analysis of the impact of anaesthetist groups on prices. We then set out our assessment of consultant groups.

### ***Anaesthetist groups—price analysis***

- 7.23 Appendix 7.1 sets out full details of our price analysis to which we refer throughout this section.
- 7.24 Table 7.1 shows a relatively higher rate of anaesthetist groups being formed between 1981 and 1990 and another spike between 2001 and 2010. This is based on a sample of 45 anaesthetist groups which provided full responses to our questionnaire. Around five out of the 26 anaesthetist groups established between 1960 and 2000

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<sup>594</sup> Bupa response to provisional findings.

<sup>595</sup> Bupa response to issues statement.

<sup>596</sup> CC3, paragraphs 186 to 190.

<sup>597</sup> CC3, paragraphs 104.

either changed from loose associations to formal legal structures or moved to collective price-setting between 2001 and 2010.

TABLE 7.1 Establishment of anaesthetist groups over time

<i>Time period</i>	<i>Number of anaesthetist groups established</i>
1960–1970	1
1971–1980	7
1981–1990	13
1991–2000	5
2001–2010	19
Total	45

Source: CC analysis.

- 7.25 We did not have enough information on the anaesthetist groups' presence and membership across UK hospitals to test systematically their possible impact on average fees charged by anaesthetists.<sup>598</sup> Therefore, our analysis covered those local geographic areas, and anaesthetist groups active in these areas, which insurers highlighted as potentially raising competition concerns, or mentioned specifically (ie 11 groups in total), as these were likely to be more indicative of raising competition problems.
- 7.26 A key aspect of the analysis of each local area and anaesthetist group was to find an appropriate control group that allowed us to compare the fees for treatments administered by consultants that belong to anaesthetist group(s) with the fees of the control group (see Appendix 7.1, paragraph 10). The more similar the circumstances that affect the fee level of the treatment offered by the two groups, the more likely that any difference in prices can be attributed to the presence of the anaesthetist group. As our control groups will not in general capture all other factors, there is some uncertainty associated with the results from our analysis. We controlled for the mix effect of different treatments performed in the different local areas by looking at six<sup>599</sup> of the ten most common treatments in the UK under general anaesthesia (see Appendix 7.1, paragraph 11).<sup>600</sup>
- 7.27 Where data was available, we conducted the analysis for each of the six treatments, as follows:
- (a) First, we conducted price analysis at the national level to give an overview on the UK anaesthetist market (see Appendix 7.1, paragraph 12(a)).
  - (b) We then focused our price analysis on local geographic areas, where insurers identified anaesthetist groups which in their view raised competition concerns.

<sup>598</sup> AAGBI provided some information about anaesthetist groups derived from a survey undertaken in conjunction with Enventure Research between December 2012 and February 2013 ([AAGBI response to annotated issues statement](#)) but did not provide details on anaesthetist groups and their membership. We requested information from the PMIs and private hospital operators on the existence of anaesthetist groups (as well as other consultant groups) that they were aware of. This information, together with the limited information provided by AAGBI and more general research carried out by the CC, identified over 150 potential anaesthetist groups in the UK. Contact details were obtained for approximately 100 such groups which were sent the questionnaire.

<sup>599</sup> Multiple arthroscopic operation on knee (including meniscectomy, chondroplasty, drilling or microfracture) (w8500); arthroscopic meniscectomy (including debridement) (w8200); phakoemulsification of lens with implant—unilateral (c7122); hysteroscopy including biopsy, dilatation, curettage and polypectomy with/without mirena coil insertion (Q1800); diagnostic endoscopic examination of bladder (including any biopsy) (m4510); surgical removal of impacted/buried tooth/teeth (f0910).

<sup>600</sup> These account for around 18 and 19 per cent of observations with non-missing CCSD codes by volume and by value respectively.

Based on the 11 areas identified by insurers, we conducted regional analysis and individual case studies (see Appendix 7.1, paragraph 12(b) and (c)).

- 7.28 In relation to our national and regional analyses, we note that, even for each specific treatment, we observe substantial price variation in anaesthetist fees across areas of the UK. Therefore, any difference between the average fees set by members of group(s) and non-members of groups<sup>601</sup> showed by our national and regional analyses could be explained by factors other than the presence of a group. We have taken this into consideration in interpreting the results of these analyses.
- 7.29 The individual case studies provide more detailed analyses that aim at better controlling for geographical variations. The analysis of price changes pre- and post-formation of the groups, or change of their legal status, is the most useful (in what follows we refer to this analysis as pre- and post-event). The difference between groups' prices pre- and post-event and those of non-groups, particularly in the same region, represents a good comparator as the only (observable) feature is the group formation. However, this could only be applied to three case studies as for the other case studies the group was formed before our period of analysis (2006 to 2012, part year). The second best comparator is independent consultants working in the same hospitals as group members, which was applied to four case studies. In theory, comparing average fees between group members and independents in the same hospital is a good comparator as the only (observable) feature that differentiates them is that they are not part of a group. However, one possible disadvantage of this approach is that independents may choose to follow the prices set by the groups. The third best comparator is comparisons with group members operating in nearby hospitals, which was applied in three case studies. We had difficulty conducting this analysis because of lack of data and information about the presence and/or size of anaesthetist groups in nearby hospitals.<sup>602</sup>
- 7.30 Our national and regional analyses<sup>603</sup> generally suggest that anaesthetist groups may charge higher prices compared with independent anaesthetists (see Appendix 7.1, paragraphs 16 to 18). However, as noted in Appendix 7.1, paragraph 6, these analyses do not control for geographical differences in anaesthetist charges.
- 7.31 In relation to the individual case studies, the results can be summarized as follows:
- (a) We did not have enough observations to conduct individual case studies for five out of the 11 anaesthetist groups.
  - (b) The evidence on half of the individual case studies undertaken (three out of six) does not suggest that the presence of the anaesthetist groups, and especially their collective price-setting, leads to higher prices. However, for these case studies we were unable to carry out what we regard as the strongest piece of analysis—the pre- and post-event price analysis.<sup>604</sup>
  - (c) For the other three case studies, where we could conduct the pre- and post-event price analysis, the evidence that the presence of the anaesthetist groups, and especially their collective price-setting, may have led to higher prices was, to some extent, mixed for two of the case studies. The summary results of our

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<sup>601</sup> Non-members include independents or members of groups who are not identified in our database.

<sup>602</sup> We note that, in our case studies, we have also compared prices of anaesthetist groups with regional averages on an annual basis (see Appendix 7.1, paragraph 12(c)(i)). Similar considerations to those made in relation to our national and regional analysis in paragraph 7.28 also apply to this analysis.

<sup>603</sup> Including comparison carried out within each case study.

<sup>604</sup> This compares the percentage change in the price charged by anaesthetist groups pre- and post-event with the percentage change in a regional average price over the same period.



analyses, as described in Appendix 7.1, paragraphs 19 to 31 for each of these case studies are set out below.

- 7.32 For case study A, the anaesthetist group in this area has a high share of all anaesthetic treatments—over 80 per cent by volume. The pre- and post-event analysis showed relatively higher average price rises, compared with the region as a whole, for five of the six treatments and lower prices for one treatment. For three out of the five treatments (with higher prices), the differences in price rises were four percentage points, two percentage points and one percentage point. For the other two treatments, the differences in price rises were 13 and 15 percentage points. For the sixth treatment, the lower price rise was minus two percentage points. The comparison with independents working in the same hospitals could only be carried out for two out of six treatments and the comparison with nearby hospitals for three out of six treatments (see Appendix 7.1, paragraph 21(d) and (e)).
- 7.33 For case study B, the anaesthetist group in this area has a high share of all anaesthetic treatments in one hospital—around 60 per cent by volume. The pre- and post-event analysis showed relatively higher average price rises, compared with the region as a whole, for four of the five treatments we had data to analyse and lower for one treatment. For two out of the four treatments with higher prices, the difference in price rises was one percentage point. For the other two treatments, the differences in price rises were eight and 19 percentage points. For the fifth treatment, the price rise after the group changed from a loose association to a formal partnership was three percentage points lower than that for the region. For this case study, we could not carry out the comparison with independents working in the same hospitals, or the comparison with nearby hospitals.
- 7.34 For case study C, the anaesthetist group in this area has a high share of all anaesthetic treatments in one hospital—above 50 per cent by volume. The pre- and post-event analysis showed relatively higher average price rises, compared with the region as a whole, for four of the four treatments we had data to analyse. The differences in price rises for two treatments were eight percentage points. For the other two treatments the price differences were 10 and 14 percentage points. For this case study, we could only carry out the comparison with independents working in the same hospitals and this could only be carried out for three treatments (see Appendix 7.1, paragraph 25(c)).
- 7.35 Bupa submitted that the anaesthetist groups in the areas examined by the CC often had very high market shares—with groups in the 11 areas the CC investigated having at least 50 per cent of anaesthetic activity in their main hospital, two of those areas having over 70 per cent and a further two areas where their share was over 80 per cent. It contended that the formation of anaesthetist groups had led to significantly higher prices for consumers in the areas studied by the CC—in particular, the CC's comparison of prices pre- and post-formation of a group showed that the formation of the group increased prices in 13 of 15 treatments studied. Bupa's own analysis, presented in response to the issues statement, found anaesthetist group prices to be on average higher than individual anaesthetists, which it said had also been repeatedly found across the CC's own measure.<sup>605</sup> Bupa also argued that in considering barriers to entry, the CC needed to determine whether individual anaesthetists provided an effective competitive constraint on groups. In its view, the CC's own evidence showed that anaesthetist groups charge over 5 per cent more on average than individual anaesthetists, consistent with them providing a limited competitive constraint. Bupa also raised some criticisms about the methodology under-

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<sup>605</sup> Bupa response to provisional findings, p7.

taken by the CC in its pricing analysis, as there had been no reporting of annual price changes associated with anaesthetist groups or an average price change for each treatment, it did not detail a sample size or whether the price changes were statistically significant. It said that there had also been no interrogation by the CC of the alleged benefits claimed by anaesthetist groups.<sup>606</sup>

- 7.36 AXA PPP submitted that the CC had incorrectly summarized the results of its pricing analysis, stating that it demonstrated an upward effect on prices from the presence of groups. It said that the three case studies presented in the provisional findings where the CC was able to develop the most probative evidence (ie pre- and post-event analysis) all yielded results that supported an AEC in that they all pointed to increased prices—in particular, relatively higher average prices were shown in case study A in five out of six treatments; case study B in four out of five treatments; and case study C in all four treatments. It said that it was of no significance that the precise measure of price effects was difficult and uncertain; it was the directional indication of price which was quite clear on the preponderance of the evidence.
- 7.37 Although the national and regional analyses generally suggest a price effect of anaesthetist groups, we have placed less weight on these analyses as they do not control for geographical differences. In relation to the individual case studies, our view remains that the evidence of a price effect of anaesthetist groups was mixed. In three of the six case studies undertaken, the evidence does not suggest that the presence of anaesthetist groups leads to higher prices. For the other three case studies, there was evidence of some price effect; however, this was not consistent across all treatments analysed for two of the case studies (A and B) but it was for one of the case studies (C). Whilst the anaesthetist groups in these three case studies have high market shares, the anaesthetist group in case study C has a lower share (about 50 per cent) than those in case studies A and B (over 80 per cent and about 60 per cent respectively). Finally, we note that, due to data limitations, we could not carry out all the analyses set out in our methodology for all treatments for all case studies.
- 7.38 We agree with Bupa and AXA PPP that in order to determine whether barriers to entry are low, it is necessary to consider the level of constraint imposed on an anaesthetist group by individual consultants in the relevant local area. In response to our provisional findings, Bupa and AXA PPP commented on barriers to entry. As we have found mixed price effects in relation to the formation of anaesthetist groups, we decided not to prioritize our resources in carrying out a detailed assessment of barriers to entry.

### ***Assessment of consultant groups***

- 7.39 Our analysis of anaesthetist group prices showed mixed results. The pricing evidence did not therefore indicate that anaesthetist groups were leading to higher prices and therefore have a widespread AEC. As noted above, the price analysis carried out at the local level on six anaesthetist groups which set prices and which were identified as having high local shares of supply and of concern to insurers showed consistent evidence of price effects in one case, mixed evidence in two cases and no price effects in the other three.
- 7.40 We did not undertake an area by area competitive assessment to identify whether a particular anaesthetist group in any local area may have market power giving rise to competition problems in that local area. In some local areas, some anaesthetist

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<sup>606</sup> [Bupa response to provisional findings](#), p13.

groups may have market power. However, to identify such local areas and whether such market power adversely affects competition would require a detailed area-by-area competitive assessment. For the reasons set out in paragraph 7.21, we do not consider that a finding of an AEC can be made on the basis of collective price setting and high market share alone. Such an area-by-area competitive assessment would require not only consideration of shares of supply and price analysis (and potentially other market outcomes) over an appropriate period of time but also consideration of any countervailing factors, including barriers to entry, the level of constraint provided by individual consultants, the likelihood of any local entry and any countervailing buyer power of the insurers.

- 7.41 Those anaesthetist groups which insurers had indicated were a particular concern and for whom we were able to undertake a price analysis showed mixed results and in particular only showed consistent evidence of price effects in one case. Given the difficulties in obtaining data on anaesthetist groups as described in Appendix 7.1, the results of the pricing analysis and the constraints on time and resources available for investigation overall, we considered that pursuing this line of inquiry was not justified. In particular, we did not consider that further work to determine whether in any local market an anaesthetist group has local market power which adversely affects competition would be beneficial.
- 7.42 A number of parties identified particular groupings involving consultants in specialties other than anaesthetics as raising competition concerns. Each such grouping was very specific in terms of the nature of the membership, the structure of the group, the specialty(ies), whether there were any fee-setting structures in place and the local area of operation. In relation to these groups, we did not receive evidence of concerns across many local areas or in particular specialties as we did for anaesthetist groups, with the exception of one consultant group.
- 7.43 Bupa raised concerns about CESP, a group of ophthalmic surgeons, operating in 38 local areas across the UK via a series of regional partnerships. Its members included at least 250 of an estimated 400 ophthalmic surgeons practising in the private healthcare sector. Each of the regional CESP partnerships jointly owned the parent entity, CESP Ltd. Bupa provided examples of CESP Bristol and CESP South-West (Devon), where CESP consultants carried out [REDACTED] per cent and [REDACTED] per cent of ophthalmology procedures for Bupa patients at the main hospitals in those areas respectively.
- 7.44 Bupa submitted that the dominance of CESP in certain local areas had resulted in higher fees for ophthalmic services. For example, in Bristol the average shortfall paid by Bupa patients to CESP consultants was £[REDACTED] compared with a national average of £[REDACTED]. It was also concerned that by negotiating collectively on behalf of its members, CESP Ltd was able to obtain higher prices from insurers.<sup>607</sup>
- 7.45 [REDACTED] We note that no other party, with the exception of [REDACTED],<sup>608</sup> raised concerns in relation to this particular consultant group. Further, Bupa did not provide evidence of a widespread effect on competition on price and/or quality arising from CESP's presence across the local regions in which it operates. We note that the evidence it submitted was of a higher than national average shortfall in one local area. We note that Bupa submitted that in previous negotiations, it had been able to agree prices within its reimbursement fee levels for the relevant ophthalmic services and secured supply from a sufficient number of independent ophthalmologists.

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<sup>607</sup> Bupa response to provisional findings, Annex A, p30.

<sup>608</sup> [REDACTED].

- 7.46 However, as set out in Appendix 7.1, Annex A, there may be a number of benefits for patients arising from consultants operating in groups which may not be confined just to anaesthetist groups. We also refer to our consideration in paragraph 7.63 below of whether insurers have buyer power with regard to consultants and the significant reduction in reimbursement levels by insurers, in particular for ophthalmology services, in recent years. We did not consider that the fact that a consultant group in a particular locality did not agree to price at the fee level set out in an individual insurer's reimbursements fee schedule was of itself evidence of market power. As with anaesthetist groups, collective setting of prices and high market shares alone do not demonstrate that competition is adversely affected. Having regard to the results of the price analysis on anaesthetist groups and the limited evidence in relation to CESP's pricing, we took the view that further detailed assessment of any particular consultant groups, including CESP, would not be justified.
- 7.47 On balance, the assessment we have carried out does not lead us to find that the formation of anaesthetist groups or other consultant groups adversely affects competition. In addition, we do not find that the formation of any individual anaesthetist group or other consultant group adversely affects competition in any local market.

## ***Countervailing power of insurers***

### *Introduction*

- 7.48 This section considers whether insurers have buyer power in relation to consultants which may be used to suppress consultant fees to a level below those which would prevail in a competitive market. If this were the case, this could lead to a shortage of consultants in private practice and/or a reduction in the quality of service provided by consultants to patients and incentives to innovate. Insurers could also distort competition between consultants if caps on the reimbursement of fees were applied to some consultants but not others.
- 7.49 The role of the insurers, and in particular their relationship with consultants, has prompted a significant number of submissions from consultants, their trade associations and members of the public. The majority of these have been published on our website and the views of consultants are summarized in Appendix 7.3.
- 7.50 In terms of the views expressed by the profession, FIPO submitted that there was clear evidence that fee capping to uneconomical levels affected patient choice. The fact that AXA PPP and Bupa were directing patients to the newly-qualified consultants (who were subject to inflexible retail price maintenance clauses) in preference to the established consultants directly affected patients.<sup>609</sup>
- 7.51 FIPO referred to an NAO report<sup>610</sup> which reported that there were, in 2012, 15,754 consultants in private practice, equating to 39 per cent of the total consultant population of 40,394. It submitted that as the NAO indicated in 2006 that the number of consultants undertaking private practice was 55 per cent, then the number of consultants undertaking private practice work in 2011/12 had reduced by one-third.<sup>611</sup> Similarly, the Private Patient Forum (PPF) noted reductions in the number of consultants working in the private sector on the basis of the same NAO figures and

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<sup>609</sup> [FIPO response to provisional findings](#), p48.

<sup>610</sup> See paragraph 7.11 above.

<sup>611</sup> [FIPO response to provisional findings](#), p43.

questioned whether the ‘directed care model’ of insurers contributed to this apparent reduction in consultants entering private practice.<sup>612</sup>

- 7.52 The Independent Doctors Federation (IDF) considered that decreasing reimbursement fees from insurers, particularly from Bupa and AXA PPP, combined with increasing expenses involved with running a private medical practice, were such that newly-appointed consultants were reluctant to enter private medical practice.<sup>613</sup> Similarly, the London Consultants’ Association was of the view that newly-appointed consultants could not be kept on grossly reduced fees in the long term, in the face of rising costs.<sup>614</sup>
- 7.53 The AAGBI was of the view that the supply of consultants to the private sector was reducing, particularly anaesthetists. It said that whilst in theory insurers, as the purchasers of 80 per cent of private healthcare, would be expected to function as advocates for the consumer, by driving down the cost and improving the quality of care, this only held true in practice if the surplus generated by the insurers’ collective buyer power was passed on to the consumer, whilst maintaining or improving choice of hospital and consultants. The evidence of insurers’ premiums consistently going up while the cost per case went down suggested that savings were being diverted into the PMIs’ profits, according to AAGBI.<sup>615</sup>
- 7.54 In this section we focus on the ways in which insurers have sought to constrain consultant fees and whether this has an AEC in the provision of consultant services. Finally, we also describe other concerns raised by consultants and their trade associations in relation to the behaviour of insurers.

### *Insurers’ fee schedules*

- 7.55 Clinician fees (which are primarily consultant fees) account for approximately 25 per cent<sup>616</sup> of insurers’ claims expenditure. The larger insurers’ strategy towards consultants, and in particular fees, appears in recent years to have been driven by, on the one hand, a desire to guarantee to cover consultants’ fees so that policyholders do not have to pay any additional fees to the consultant, and on the other hand a desire to manage claims costs so far as possible by limiting consultants’ fees where possible.
- 7.56 All the insurers publish fee schedules or guidance setting out the level of consultant fees they reimburse under their policies. The fee schedules use a set of agreed clinical codes known as Clinical Coding and Schedule Development (CCSD) codes, with each insurer deciding their fee levels independently. These procedure codes were developed by the Clinical Coding and Schedule Development Group<sup>617</sup> and were first introduced in 2006 to provide a consistent coding system across the industry. Bupa’s fee schedule has approximately 2,000 separately listed procedures. Each procedure covered in Bupa’s Schedule of Procedures has a code, appropriate narrative and complexity rating. There are 25 complexity ratings, which sit under five broad categories: Minor, Inter, Major, Major Plus and Complex Major (CMO), with separate schedules for surgical and anaesthetist fees. Under each category, there are sub-categories ranging from 1 to 5 (eg Minor 1 to Minor 5). Minor 1 is the least

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<sup>612</sup> PPF response to provisional findings, p2.

<sup>613</sup> IDF response to Remedies Notice.

<sup>614</sup> London Consultants’ Association response to provisional findings.

<sup>615</sup> AAGBI response to provisional findings, p2.

<sup>616</sup> Laing & Buisson, *Private Acute Medical Care 2012*.

<sup>617</sup> Established by Bupa, AXA PPP, Aviva, WPA and Cigna. Current members are Bupa, AXA PPP, Aviva, PruHealth and Simplyhealth.



complex (and for surgeons had a reimbursement rate of £91 in December 2013) while CMO5 is the most complex (and for surgeons had a reimbursement rate of £2,030 in December 2013).

- 7.57 Bupa's fee schedule, also known as Bupa Benefit Maxima, is regarded as the industry standard and consultants and insurers submitted that it was generally perceived as having the lowest reimbursement rates of the insurers. Until recently, it had not been materially revised since the introduction of CCSD codes in 2006.<sup>618</sup> Over time, therefore, the Bupa Benefit Maxima has become the benchmark for consultant fees, acting effectively as a minimum fee schedule for consultants in the private healthcare sector.<sup>619</sup> AXA PPP confirmed that the level of a consultant's fees is influenced by the PMI's schedule and that Bupa's Benefit Maxima represented a minimum level of charging. AXA PPP submitted evidence showing that a significant proportion of consultants charged in line with or above the Bupa Benefit Maxima.<sup>620</sup>
- 7.58 Bupa said that in the period from October 2012 to September 2013, [X] per cent of its spending on consultant fees was for treatments covered by its Benefit Maxima for surgical and anaesthetic procedures. Aviva indicated that in 2013, its fee schedule covered approximately [X] per cent of fees paid to consultants.<sup>621</sup> Fees for diagnostics<sup>622</sup> and outpatient consultations were the main fees not covered by the PMI fee schedules or fee guidance. Insurers generally agreed, for example, consultation fees and diagnostic fees individually with consultants and included annual limits on the reimbursement of outpatient procedures in their policies. This was the main mechanism for controlling such fees.<sup>623</sup>
- 7.59 Insurers—in particular the largest, Bupa and AXA PPP—have embarked in recent years on a number of initiatives to seek to control their costs in relation to consultant fees, whilst also seeking to reduce the need for policyholders to pay additional fees to the consultant. Such initiatives may include:
- (a) AXA PPP said that in order to provide greater clarity to policyholders, in 2011 it published a fee schedule similar to Bupa's Benefit Maxima, whereas its policies had previously reimbursed on the basis of 'reasonable and customary fees charged in the market'.<sup>624</sup>
  - (b) Bupa has been carrying out full reviews of its fee schedules, and Aviva is also carrying out a rolling review of its fee schedules, prioritizing procedures according to the degree of the problem which they cause (ie procedures where its customers regularly experience shortfalls or where consultants are concerned that the fee for a procedure does not reflect their work).<sup>625</sup>
  - (c) Some insurers have introduced a requirement on policyholders under some insurance policies to obtain open referrals. Under an open referral, the referring clinician does not name the consultant (and/or hospital) but merely specifies the nature of the condition, enabling the PMI to direct policyholders to consultants (and hospitals) whose fees are the lowest.

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<sup>618</sup> However, many consultants and their trade associations submitted that in reality there had been no increase in reimbursement rates at least since the mid-1990s.

<sup>619</sup> 58 per cent of consultants in our survey set their fees at the same reimbursement level as Bupa and 32 per cent at AXA PPP's (GP and consultant survey, Table E10 CC).

<sup>620</sup> AXA PPP response to issues statement, paragraph 15.3.

<sup>621</sup> Aviva response to annotated issues statement, paragraph 2.4.

<sup>622</sup> Generally, diagnostics and outpatient consultations are not covered by the PMIs' fee schedules as opposed to surgical procedures.

<sup>623</sup> Bupa response to issues statement.

<sup>624</sup> AXA PPP response to issues statement, paragraph 15.3.

<sup>625</sup> Aviva response to issues statement, paragraph 5.5.14.

- (d) Bupa and AXA PPP have introduced new consultant contracts under which the relevant consultants cannot charge above the PMI's fee schedule, thus making the PMI's fee schedule the maximum amount such consultants can charge for their services.

7.60 We describe below key aspects of each of these initiatives.

### *Review of PMI fee schedules*

- 7.61 As noted above, AXA PPP introduced a schedule of fees in 2011 for its policyholders. The fee schedule was set at a level that AXA PPP considered to be the mode of consultant fees for each procedure broadly in line with Bupa's Benefit Maxima.<sup>626</sup>
- 7.62 Between January 2011 and July 2012, Aviva reviewed 128 procedures, 63 per cent of which were adjusted upwards and only 11 per cent of which were adjusted downwards.<sup>627</sup> Since July 2012, it has reviewed a further 73 procedures,<sup>628</sup> of which the fee level was increased for 37 per cent and decreased for 30 per cent, with no change to the remaining procedures.
- 7.63 However, it is Bupa's review of its Benefit Maxima which has had a significant impact on consultant fees, given that it is regarded as the industry standard and the lowest reimbursement schedule, as described in paragraph 7.57 above. Bupa said that a procedure's level of reimbursement was changed if a complexity review had found that a procedure's complexity had changed over time, determined by clinical factors. By June 2012, of those procedures reviewed,<sup>629</sup> 49 saw increases in rates of on average 19 per cent, but 184 were reduced by an average of 32 per cent. Some procedures had significant changes in reimbursement rates, including cataract surgery fees. Bupa stated that its previous fee represented an approximate hourly rate in excess of £2,000. As of July 2012, the fixed rate was £567.<sup>630</sup> Since June 2012, Bupa has conducted further complexity reviews in plastic surgery and radiotherapy, for which complexity rating or rates were increased for eight procedures, but reduced for 30. A further 22 procedures had either been added or removed.
- 7.64 Bupa stated that the review was carried out by Bupa's in-house team of clinicians and analysts with input from external specialists who did not treat Bupa patients. Bupa explained that since the start of 2013, it had been its practice to undertake a one-month consultation with all Bupa-recognized consultants who had performed a procedure which was to change before revising its Benefit Maxima levels. Reimbursement levels would be amended based on relevant medical feedback before notifying consultants one month in advance of final adoption.<sup>631</sup> However, it did not inform policyholders of changes to its Benefit Maxima as it did not consider that such changes impacted on the overwhelming majority of its policyholders. However, where a policyholder sought pre-authorization and wished to see a consultant whose fees could not be guaranteed (ie the consultant had not agreed

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<sup>626</sup> AXA PPP response to issues statement, paragraph 15.3.

<sup>627</sup> Aviva response to issues statement, paragraph 5.5.15.

<sup>628</sup> Procedures were reviewed in specialisms including [§].

<sup>629</sup> Such procedures reviewed by June 2012 included procedures in the following specialisms: [§].

<sup>630</sup> We have received a number of complaints both from consultants and from patients with regard to Bupa's reduction in the level of cataract reimbursement in particular.

<sup>631</sup> Bupa told us that in 2013, for the first time it had a consultation period with consultants in plastics and radiotherapy as part of its fee review in these specialties.

with Bupa to charge only within its Benefit Maxima), Bupa would inform the policyholder that they may need to pay a shortfall.<sup>632</sup>

- 7.65 In 2013, AXA PPP said that it had been looking at its schedule of fees and reviewing areas where customers were experiencing shortfalls more frequently than acceptable, [REDACTED].
- 7.66 PruHealth undertook a review of the complexity for 153 procedures in 2013. It increased the complexity rating for 20 per cent of procedures, but reduced it for 56 per cent. A further 20 per cent were reclassified as the procedure took place at the same time as a consultation, and for 4 per cent a new complexity was provided. It also increased its reasonable and customary fees by 2 per cent.
- 7.67 In addition to reviewing the level of reimbursement for individual procedures, the insurers have also reviewed the circumstances in which consultants are reimbursed for multiple procedures under the same anaesthetic. For example, from 1 July 2012, Aviva no longer reimburses for more than three procedures in one theatre session in line with the other insurers.<sup>633</sup> In August 2012 Bupa introduced new codes for more complex types of anaesthesia which previously had been charged for mainly through a single code. Bupa also ceased to pay consultants for administering simple local anaesthetic as it considered this to be part of the surgical fee.

### *Consultant fee capping*

- 7.68 As noted in paragraph 7.14, Bupa and AXA PPP have introduced new recognition criteria for new consultants. Bupa and AXA PPP<sup>634</sup> said that these new criteria were aimed at addressing what they termed shortfalls. Where a consultant's fees were in excess of an insurer's reimbursement rate, a consultant generally may charge the patient the difference, assuming the insurer did not meet the difference. This difference between the insurer's reimbursement rate and the consultant's fee was termed a top-up fee if the patient was aware of and agreed to pay the difference in advance of treatment. However, if the consultant for whatever reason<sup>635</sup> had not made the patient aware of this potential difference in advance of treatment, the difference was termed by the insurer as a shortfall.
- 7.69 According to the insurers, shortfalls are identified by policyholders as a key concern. Bupa stated that in 2013, for [REDACTED] per cent of surgical procedures and [REDACTED] per cent of anaesthetic procedures, the consultant's fees were higher than Bupa's Benefit Maxima. Aviva stated that in 2013, approximately [REDACTED] per cent of its recognized consultants invoiced for fees exceeding its fee schedule,<sup>636</sup> and that as a result, approximately [REDACTED] per cent of its policyholders might have an additional fee to pay to consultants as a result of Aviva not reimbursing in full the consultant's invoiced fees.<sup>637</sup> PruHealth indicated that between August 2012 and August 2013, [REDACTED] per cent of its consultants charged [REDACTED] its benchmarked rates, while [REDACTED] per cent

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<sup>632</sup> See paragraph 7.68 for a description of what an insurer means by 'shortfall.'

<sup>633</sup> <http://www.aviva.co.uk/health-insurance/practitioner-zone/online-fee-schedule/important-announcements.html>.

<sup>634</sup> Bupa response to issues statement, paragraph 6.74 et seq. AXA PPP response to annotated issues statement.

<sup>635</sup> Such reasons may include insufficient knowledge of the patients' PMI policy, not being aware of changes to the PMIs' reimbursement rates, treatments requiring multiple procedures and unforeseen treatments/complications. As noted elsewhere, we have been provided with evidence that this is particularly an issue in relation to anaesthetists' fees as the anaesthetists may only meet the patient on the day of surgery and it is generally the consultant surgeon who selects the anaesthetist for their theatre list and may not consider the anaesthetist's fees or the patient's particular PMI policy in doing so.

<sup>636</sup> Aviva response to annotated issues statement, paragraph 2.4.

<sup>637</sup> However, Aviva indicated that this did not necessarily mean that the policyholder would pay the difference as consultants might invoice the PMI for a higher fee and then not seek to charge the differential in reimbursement to the policyholder. Bupa and AXA PPP similarly told us that they could not confirm final consultant charges as they did not generally know unless their policyholder raised the matter with them whether the consultant invoiced the patient directly or for how much.



charged [X] per cent [X] those rates.<sup>638</sup> Several insurers explained that they frequently reimbursed consultant fees in full over and above their fee schedules, in particular where the patient was not aware of the likelihood of a differential. Insurers therefore sought ways to guarantee that their policyholders did not experience any shortfalls in relation to consultant fees as well as reducing their claim costs in covering such differentials.

- 7.70 Under the AXA PPP scheme introduced in 2008, AXA PPP required all newly-recognized consultants, who were also largely newly qualified, to sign up to an agreement whereby in order to be recognized by AXA PPP they must charge AXA PPP insured patients only fees set within its fee schedule and agree not to charge AXA PPP insured patients any top-up fees.<sup>639</sup> We refer to such consultants as ‘fee-capped’ consultants. For such consultants, AXA PPP’s reimbursement rate therefore is the maximum fee that the consultant can charge for their services. AXA PPP told us that as at 31 December 2013, around [X] per cent of its 24,000 recognized consultants were subject to this contract, compared with [X] per cent in July 2012.<sup>640</sup> AXA PPP also told us that between 2011 and 2013, it had signed up on average each year [X] previously recognized consultants (ie those recognized prior to 2008) to the new contract. It had not seen any change in the number of new consultants applying for recognition since the introduction of the new contract.
- 7.71 In addition to the [X] per cent of consultants who are fee-capped in 2013, approximately [X] per cent of AXA PPP’s recognized consultants are fee-assured based on a ‘usual and customary approach’. There is no contract in place between AXA PPP and these consultants but they have historically charged within reimbursement levels deemed acceptable by AXA PPP. However, if such a consultant were to routinely charge AXA PPP policyholders significantly higher fees than they previously had, AXA PPP would review its charges and practice. If, after discussion with AXA PPP, this charging practice were to continue, the consultant would then be told that they were no longer on AXA PPP’s list of fee-assured consultants, and their fees would be capped and limited to the published schedule. This meant that AXA PPP did not recommend such consultants to policyholders, and when a policyholder sought pre-authorization to see a non-fee-assured consultant, AXA PPP informed the policyholder that they might be liable for additional fees. However, AXA PPP policyholders could use their benefits to see such consultants and were free to pay top-up fees.
- 7.72 Although newly-recognized consultants from 2008 must adhere to AXA PPP’s fee schedule, AXA PPP told us that it monitored the number of fee-capped and fee-assured consultants that it recognized to ensure that its policyholders had adequate choice. AXA PPP also confirmed that it would keep under review the level at which fees were capped as those fee-capped consultants became more experienced<sup>641</sup> in order to keep the proportion of fee-assured and fee-capped consultants at over [X] per cent of its recognized consultants. This meant that after a number of years, some consultants who were contractually obliged to charge within AXA PPP’s fee schedule might be able to increase their fees. [X]
- 7.73 As at December 2013, Bupa had approximately 19,000 active<sup>642</sup> recognized consultants and a total of 25,883 recognized consultants. Bupa had a number of different

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<sup>638</sup> PruHealth indicated that in such cases it would challenge the fee and seek to negotiate with the relevant consultant. This was usually successful. Policyholders would not need to pay any differential as PruHealth told us that it would always pay consultant fees in full, to ensure that its customers did not suffer a shortfall in benefit.

<sup>639</sup> AXA PPP response to issues statement, Section E; AXA PPP response to annotated issues statement, paragraph 5.20 et seq.

<sup>640</sup> AXA PPP response to issues statement, Table 6.

<sup>641</sup> AXA PPP response to annotated issues statement, paragraph 5.20 et seq.

<sup>642</sup> Bupa defines this to mean consultants who have billed Bupa between November 2012 and October 2013.

categories of recognized consultants depending on when the consultant became a recognized Bupa consultant and whether the consultant had agreed to charge only within agreed fee levels.

- 7.74 Prior to 2010, Bupa ran a voluntary scheme under which, if a consultant agreed to charge within Bupa's reimbursement rates for all treatments covered by the Benefit Maxima, Bupa would pay a retrospective annual bonus of [X] per cent of the consultants' charges (excluding consultation fees). Consultants on the scheme, some [X] as at June 2010, were advised to policyholders as 'fee assured'. In June 2010, Bupa closed the voluntary scheme to new members and introduced a new mandatory consultant contract, which sets out the terms of recognition between Bupa and consultants who are newly recognized as of June 2010. Like AXA PPP, as a condition of recognition under the terms of Bupa's new contract, consultants are required, among other things, to charge Bupa policyholders in accordance with the fees set by Bupa.<sup>643</sup> They are not permitted to charge Bupa-insured patients any amount over and above the Bupa agreed fees including for consultations, even if this has been discussed with the patient in advance of treatment.<sup>644</sup> Such consultants are referred to by Bupa as 'Contract Consultants'.
- 7.75 If a consultant was already recognized by Bupa in June 2010, they were not required to sign up to the new contract capping their fees. However, Bupa has encouraged pre-2010-recognized consultants to sign up voluntarily to a new contract. Between 2011 and 2013, it has signed up around [X] pre-2010-recognized consultants to its contract and refers to such consultants as 'Premier Partners'. In return for agreeing to have their fees capped, such consultants are given additional benefits by Bupa such as enhanced promotion by Bupa to GPs, Bupa policyholders and the public on the Bupa consultant finder facility on its website. Such Premier Partners also receive a higher scoring and are, all else equal (see paragraph 7.85 below), listed higher in Bupa's consultant search engines.
- 7.76 As at December 2013, a total of approximately [X] consultants were therefore fee capped (ie either Contract Consultants or Premier Partners).<sup>645</sup> Bupa also has informal agreements with some consultants that they will bill within its Benefit Maxima (referred to as 'Consultant Partners') and a number of recognized consultants who habitually bill within its Benefit Maxima (referred to by Bupa as 'Guarantee Consultants'). Approximately [X] consultants fall into these two further categories.
- 7.77 In addition, since August 2011 Bupa has undertaken a program to negotiate with consultants whose charges are higher than 90 per cent of their 'peers', adjusting for specialty, sub-specialty interests, geography and, in some cases, experience. Bupa approaches all such consultants and seeks to negotiate a lower fee rate which it regards as reasonable. Since August 2011, over [1000] Bupa-recognized consultants have been asked to provide a clinically valid reason for their high fees or to lower their fees when billing to Bupa customers. Twenty-seven consultants have been derecognized as a result of this process since August 2011, the remaining consultants having agreed to lower their fees or are still in discussions with Bupa over whether to do so.
- 7.78 Bupa said that none of its policies limited policyholders to using only fee-capped consultants and all policyholders, including those on open referral policies, could access

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<sup>643</sup> [Terms for Bupa Recognised Consultants \(newly recognised from 2010\)](#).

<sup>644</sup> Bupa told us that some procedures could involve unexpected complications which might not be reflected in the complexity ratings. In such cases, consultants could request uplift payments. All uplift decisions were reviewed by Bupa's Medical Directors and funding was approved where requests were medically justified.

<sup>645</sup> 36 per cent of consultants in our survey stated that they had agreements with Bupa to charge in line with Bupa's fee schedule compared with only 13 per cent for AXA PPP. [GP and consultant survey](#), Table E12.

non-fee-capped consultants under its policies. However, unlike other insurers, as explained above, Bupa derecognizes consultants whose fees it regards as too high, meaning that policyholders irrespective of their policy type can no longer access such consultants under the terms of their policies. As noted above, this has affected 27 consultants since 2011, less than 0.2 per cent of consultants in private practice. In addition, where there is an opportunity to guide a patient, Bupa guides all policyholders (irrespective of their policy type) towards consultants who have agreed to charge within their Benefit Maxima, whether fee-capped (Contract Consultants and Premier Partners) or otherwise fee-assured (Consultant Partners and Guarantee Consultants).<sup>646</sup> It does this (a) through open referral,<sup>647</sup> (b) by prioritizing in its consultant rankings those consultants who are fee-assured so that patients are more likely to select such consultants when seeking authorization from Bupa whether on an open referral policy or not; and (c) by advising policyholders at pre-authorization that should they select a consultant who was not fee-assured they risked being charged top-up fees and would recommend other fee-assured consultants.

- 7.79 Policyholders on open referral policies, approximately [§] per cent of Bupa policyholders ([§] per cent of which are corporate members), can only be treated by 'plan-approved' consultants. These are Bupa-recognized consultants whom Bupa has 'deemed do not exhibit any unexplained treatment variations in their practice', based on the consultants' clinical practice<sup>648</sup> and the overall cost of care<sup>649</sup> provided by the consultant. An individual consultant's status as a 'plan-approved' consultant is not fixed but may vary over time depending on the consultant's practice and those of peers. Bupa stated that 'plan-approved' consultants comprised approximately 90 per cent of Bupa's recognized consultants and, as noted previously, Bupa recognized over 25,000 consultants compared with approximately 22,000 estimated active consultants in 2011/12 in private practice.
- 7.80 During 2013, Aviva made a number of changes to its specialist registration terms and conditions, including that new consultants seeking to obtain 'approved status' must agree to charge in accordance with its fee schedule and may not ask Aviva policyholders to pay a top-up fee. However, the registration process allows new consultants to opt out of obtaining approved status. Such consultants remain recognized but Aviva advises its policyholders that a top-up fee may be payable.
- 7.81 PruHealth is not proposing to introduce similar consultant fee-capping contracts. WPA and Simplyhealth told us that they did not cap the level of fees at which their consultants may charge.<sup>650,651</sup> While both publish a schedule of customary and reasonable fees reimbursement maxima for their consultants, consultants are permitted to charge patients above published fee levels, on the basis that the patient is aware of and is willing to contribute any shortfall. In WPA's case, the consultant must also make their fees clear to the patient in advance in writing. As far as we are aware, WPA does not have plans to introduce fee-capping contracts for its consultants. [§]

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<sup>646</sup> When a policyholder uses the online search tool to find a consultant, the 'fee-assured' consultants are listed first and Premier Partners will be listed above all other consultants.

<sup>647</sup> See paragraphs 7.82–7.92 below for further details on open referral.

<sup>648</sup> For example, whether the consultant reports outcome data to clinical registries, the type of procedures they perform, the type and volume of diagnostics tests and whether these are outside the 90<sup>th</sup> percentile for that speciality.

<sup>649</sup> For example, consultants who practise in Bupa's view in a way that generates levels of costs that are clearly out of line with peers.

<sup>650</sup> [Simplyhealth hearing summary](#), p3.

<sup>651</sup> [WPA hearing summary](#), p2.

## Open referral

- 7.82 Bupa, AXA PPP, Aviva and PruHealth have introduced PMI policies in the corporate sector under which the policyholder is required to obtain an open referral from their GP or other referring clinician. Under this open referral process, the referring clinician does not name the consultant (and/or hospital) but specifies the specialty or sub-specialty. The policyholder then contacts their insurer and depending on the insurer and the terms of the policy, the insurer advises the patient on the appropriate consultant.<sup>652</sup>
- 7.83 Bupa initially launched open referral policies in 2011 (in a pilot stage with two corporate clients). Open referral policies were offered to all corporate customers from January 2012. Bupa has been actively encouraging all its policyholders, whether under an open referral policy or not, to obtain open referrals. From July 2013, Bupa commenced offering open referral policies to personal customers on a limited basis.<sup>653</sup> As at 31 December 2013, around [X] per cent of Bupa's total policyholder base held an open referral policy, with [X] per cent of those being corporate members.
- 7.84 Bupa considered that open referral policies enabled it to constrain claims costs by directing its policyholders to fee-assured consultants. Bupa also argued that open referral enabled it to direct its policyholders away from those consultants which it considered might overtest or overtreat patients. Unlike GPs, who in Bupa's view often referred patients to consultants 'with little or no objective data about a consultant's care practices or charges', Bupa stated that it had a 'comprehensive database' giving it an 'insight into which consultants provide higher quality care'.<sup>654</sup>
- 7.85 Policyholders under open referral policies, unlike other policyholders, are required to obtain pre-authorization before seeing a consultant or undergoing any treatment. All policyholders are encouraged to bring Bupa's standard open referral form to their GP appointment and the GP specifies the policyholder's symptoms and clinical requirements (clinical specialty, sub-specialty and whether an appointment is needed urgently). Bupa then gives the policyholder a choice of generally two consultants. The choice of consultants provided by Bupa depends on several factors. For example, Bupa considers the location of the policyholder and the specialty required. However, Bupa's consultant scoring criteria also include cost criteria such as the consultant's historical outpatient fees, their average treatment costs, the charges of the hospital at which the consultant practises and whether the consultant is a Premier Partner, Contract Consultant or Consultant Partner (see paragraphs 7.73 to 7.78 above).<sup>655</sup> As explained previously, policyholders on open referral policies are limited to 'plan-approved' consultants, a subset of Bupa-recognized consultants as described in paragraph 7.79.
- 7.86 AXA PPP started to offer policies to corporate customers requiring open referral in May 2010, although such policies limited access to 70 BMI facilities and BMI advised the policyholder on the appropriate consultant. In January 2013, AXA PPP launched

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<sup>652</sup> As indicated in Section 6. In that section, guided referrals may also apply in relation to the hospital provider and not just the consultant.

<sup>653</sup> The product is not open to new customers but only for renewals for customers on legacy products who have sought an option to control cost.

<sup>654</sup> [www.bupa.co.uk/intermediaries/int-news/int-bupa-updates/bupa-updates-archive/open-referral-news/Open-referral-letter](http://www.bupa.co.uk/intermediaries/int-news/int-bupa-updates/bupa-updates-archive/open-referral-news/Open-referral-letter).

<sup>655</sup> Bupa's consultant scoring system has four categories, with the weightings in brackets: geography (100 per cent), specialism key word matching (80 per cent); consultant profile (80 per cent); and fee surety (50 per cent). Under consultant profile Bupa has four measures, two relating to cost and two non-cost-related, variations in treatment and level of readmissions where it has such data.

its Healthcare Pathway policy (Pathways) which covers a network of 120 facilities,<sup>656</sup> and has [X] members from large corporate customers, representing around [X] per cent of its estimated 2 million national policyholders.<sup>657</sup> Like the Bupa open referral policies, Pathways is also directed at corporate customers and is very similar to Bupa's in requiring policyholders to obtain an open referral from their GP (both in terms of hospital and consultant). Policyholders are provided with a choice of up to three consultants from AXA PPP's list of fee-capped and fee-assured consultants. AXA PPP also offers a Fast Track appointment booking service under which it makes the bookings for first appointments.<sup>658</sup> Policyholders not on mandatory open referral products can also obtain open referrals and use AXA PPP's services such as the Fast Track appointment service.<sup>659</sup> However, AXA PPP does not at present, as actively as Bupa, encourage personal policyholders to obtain open referrals. [X]

- 7.87 Aviva recently launched a similar scheme (Guidewell) for large corporate customers (with 250 or more lives covered) under which policyholders are required to obtain open referrals both in relation to the consultant and the hospital. In addition, under such policies musculoskeletal problems are managed through Aviva's BacktoBetter rehabilitation service, which enables policyholders to bypass the need for a GP referral at all.<sup>660</sup> The total number of lives on the Guidewell scheme to date is [X] or [X] per cent of total lives covered in Aviva's large corporate customer segment.
- 7.88 A number of PruHealth customers have a legacy insurance product, known as Guided Option, which requires the customer to obtain an open referral. Under these policies the customer is offered a choice of consultant by the hospital as opposed to PruHealth. PruHealth currently has no plans to offer this product as a single policy option. PruHealth stated that it did not direct patients to providers as it saw treatment as being clinically rather than insurance led.
- 7.89 We received a large number of submissions from consultants and their representative bodies which are critical of these initiatives and the way in which in particular Bupa and to a lesser extent AXA PPP engage with consultants more generally. Whilst the submissions we received are not necessarily representative of the views of all consultants, several of the trade associations have been relatively strong in their criticisms of the behaviour of some of the insurers and some insurers have themselves expressed concern at some of the initiatives being adopted and/or the manner of their adoption, in particular by Bupa.<sup>661</sup>
- 7.90 In particular, the IDF submitted the views of a number of its member GPs, which expressed concern that when a GP referred a patient to a consultant there were a number of aspects to consider, including the condition of the patient, the expertise of the specialist, the availability and impairment of the patient and the personality of the patient and the consultant. The IDF argued that as a result, open referral could never take into account the specific needs of individual patients. It also stated that a GP could be held responsible if an inappropriate referral was made and a patient was harmed. However, insurers did not have such responsibility.<sup>662</sup>

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<sup>656</sup> BMI told us that it offered AXA PPP a deep discount of [X] per cent to contract by way of guided referral and that it insisted that discounts be used to support lower costs to the consumer of the Pathways product.

<sup>657</sup> [www.axa.co.uk/healthcare/personal/](http://www.axa.co.uk/healthcare/personal/).

<sup>658</sup> [www.axapphealthcare.co.uk/](http://www.axapphealthcare.co.uk/).

<sup>659</sup> AXA PPP response to annotated issues statement, paragraph 5.29.

<sup>660</sup> [www.aviva.co.uk/healthcarezone/about-us/news/latest-news/guidewell-sustainable-and-affordable-pmi/](http://www.aviva.co.uk/healthcarezone/about-us/news/latest-news/guidewell-sustainable-and-affordable-pmi/).

<sup>661</sup> [X] expressed specific concern in regard to the severe restriction of consultants' fees and linking consultant recognition to such restricted fees.

<sup>662</sup> IDF supplemental response to provisional findings.



- 7.91 FIPO was of the view that in its provisional findings the CC had ignored the concerns expressed in relation to open referral schemes by anyone involved in medical care, apart from itself, including among others the BMA, the British Orthopaedic Association and the PPF, which suggested that such schemes interfered with clinical decisions, to the long-term detriment of patients.<sup>663</sup> Spire also told us that open referral policies were a growing trend and that insurers used them to steer patients to hospitals where they got the best price, but not necessarily the best quality,<sup>664</sup> while Ramsay and Nuffield expressed concerns should open referrals be based purely on price, rather than clinical judgements or the best interests of the patient.<sup>665</sup> The London Consultants' Association was concerned that the adverse clinical effects of an insurance-led referral system to patients had been underestimated. Like FIPO, in its view unless it was clarified that a patient had a right to use the benefits available under their policies to see a consultant of their choice, the CC's proposed remedies in particular relating to greater information on performance and fees of consultants it considered would have limited impact.<sup>666</sup>
- 7.92 Of the individual consultants who made submissions in relation to open referral, it was a commonly held view that open referral interfered with traditional referral pathways and limited patient choice. Many considered that insurers should not be permitted to make clinical decisions relating to consultants and/or courses of treatments (see Appendix 7.3).

### *Assessment of insurers' buyer power*

- 7.93 In light of the above, we focused our investigation on two key issues relating to consultants fees: first insurer reimbursement rates and secondly insurer restrictions on top-up fees including the impact of open referral policies. In doing so, we make two general observations. First, in the context of consultant fees, the consultant is the supplier of a service and the insurer is the payor and can therefore be characterized as the buyer of services. Strong buyers can generally lead to increased competition and lower prices for consumers.
- 7.94 In the absence of the insurers constraining consultants' fees, it is unclear how such fees would be constrained for insured patients—given that the insurer is responsible for funding the treatment rather than the insured patient. Consultants are critical to the insurers' business. The key perceived benefits of privately-funded healthcare are treatment by a consultant of choice and treatment at a time and place convenient to the patient.<sup>667</sup> Moreover, patients' experience of privately-funded healthcare is, in the main, driven by the consultant. Insurers therefore depend for their business on a supply of high quality widely located and available consultants across most specialties for their policyholders.

### *PMI reimbursement rates*

- 7.95 Bupa told us that its Benefit Maxima was key in constraining consultants' charges. Without the insurers, in Bupa's view, consultants would not have any constraints on their fees. It provided analysis comparing consultant reimbursement per member by

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<sup>663</sup> [FIPO response to provisional findings](#), Annex A.

<sup>664</sup> [Spire response to provisional findings](#), p27.

<sup>665</sup> [Ramsay hearing summary](#); [Nuffield hearing summary](#).

<sup>666</sup> [London Consultants Association response to provisional findings](#); [FIPO response to provisional decision on remedies](#).

<sup>667</sup> 76 per cent of respondents to our patient survey stated that the main reason for going private was reduced waiting times, 52 per cent availability of appointment times, 39 per cent ability to choose a specific consultant, 38 per cent better quality of care, 25 per cent better after care, 25 per cent better clinical care, 23 per cent ability to be in the top highest ranking reasons for selecting PMI ([CC patient survey](#), Table B1).

Bupa between 2007 to 2011 for outpatient consultations which were not subject to the Benefit Maxima and for surgical procedures which were subject to the Benefit Maxima. Bupa's analysis showed that spend per member for consultant consultations grew at a significantly faster rate than for surgical procedure spend per member and general inflation (RPI).

- 7.96 Bupa did not consider that its Benefit Maxima should be automatically increased each year. In its view, the size of the PMI market was similar to that in the mid-1990s but the number of consultants available for private work had increased over the period. Moreover, in its view, improvements in technology had reduced the complexity of, and the skill and time required for, a number of treatments.
- 7.97 AXA PPP made similar observations regarding the lack of constraints on consultants' fees.<sup>668</sup> In particular, AXA PPP stated that newly-qualified consultants charged less than the average consultant per procedure and had lower episode costs. Like Bupa, AXA PPP also said that it had no evidence that consultants who charged above its reimbursement levels were of higher quality. AXA PPP also compared its reimbursement rates with those available in the NHS. For example, according to AXA PPP, NHS Trusts paid approximately £120 per hour for additional work by a consultant compared with an hourly rate in excess of £450 in the private sector.<sup>669</sup>
- 7.98 As set out in Appendix 7.2, our preliminary analysis and the evidence submitted by parties on consultants' fees did not suggest that consultants' fees were either increasing or decreasing significantly. The extremely wide variation in the levels of consultant earnings and costs depending on specialty, locality and size of practice would have made any profitability analysis extremely difficult, resource intensive and likely to be inconclusive. Appendix 7.2 contains further analysis by Stanbridge Associated Limited, which suggests that net average incomes<sup>670</sup> for ten key specialties between 2005 and 2010 have been relatively stable over time. A number of factors have impacted on consultant fee income in recent years independent of the insurers, including a decline in demand both from insured<sup>671</sup> and self-pay patients, decreased NHS waiting times, improved NHS consultant remuneration, greater NHS commitment requirements, and an increase in the number of consultants.<sup>672</sup>
- 7.99 In addition, on the basis of the information we received, we are not able to ascertain whether the level of PMI reimbursement rates mean that consultants' charges are being constrained by the insurers at a level which is more or less appropriate compared with the charges previously made. It is evident that the insurers' strategies in relation to consultants' fees over the last few years are tending to constrain consultants' fees. This has combined with the insurers' increasing role in determining the choice of consultant for particular treatments/referral journeys through the use of open referral and other specialist referral schemes,<sup>673</sup> increasing the impact of the insurers' steps to lower their reimbursement rates for many procedures.

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<sup>668</sup> [AXA PPP response to issues statement](#) and [AXA PPP response to annotated issues statement](#).

<sup>669</sup> [AXA PPP response to annotated issues statement](#), paragraph 5.21.

<sup>670</sup> Income after accounting for practice costs including staff costs, consulting room hire, professional indemnity.

<sup>671</sup> See paragraph 3.75.

<sup>672</sup> BMA survey of consultants reported that the most common explanations for consultant earnings being flat or declining were a decline in the self-pay market (64 per cent), decreased NHS waiting times (58 per cent) and an increase in the number of consultants (46 per cent).

<sup>673</sup> Such as Aviva's musculoskeletal (MSK) rehabilitation service under which a GP referral is not required and Aviva directs customers to its strategic clinical partners who advise on treatment and the choice of provider. Bupa has a Specialist Eye Care process enabling optometrists to refer directly to Bupa's team. Policyholders with muscle, bone or joint conditions have the option not to obtain a GP referral, and instead to contact Bupa direct, which will then arrange a physiotherapist assessment to provide advice and refer the policyholder if necessary.

7.100 However, we have not seen evidence to indicate that the insurers' reimbursement rates are leading to lower quality of services, to lower incentives to innovate or dissuading consultants from entering or remaining in private practice in sufficient numbers to affect consumer choice or cause long-term detriment. Further, it is in the insurers' own commercial interests<sup>674</sup> to balance carefully their desire to constrain consultant fees (the benefits of which can be passed on to their policyholders in the form of lower premiums) and their need to ensure that their policyholders have access to high-quality, appropriately located and available consultants—such access is fundamental to their business as insurers. Thus, it would not be in the insurers' own interest to drive consultant charges so low that quality and innovation is negatively affected—and insurers are, therefore, unlikely to do so. We make a few observations in paragraphs 7.124 and 7.125 in relation to information provided to policyholders and consultants themselves in particular with regard to these matters.

### *Top-up fees*

7.101 Bupa and AXA PPP argued that their fee-capping of consultants enabled them to offer their policyholders the assurance that consultants' fees would be fully covered, with 'no surprises'. They also argued that price was not necessarily an indicator of quality.<sup>675</sup>

7.102 Consultants and some of their trade associations<sup>676</sup> argued that:

- (a) Bupa and AXA PPP represented a significant proportion of the market for consultants and through requiring consultants only to charge up to their reimbursement rates were determining the maximum fees a consultant may charge.
- (b) Consultants could no longer set their fees based on their experience, their specialist knowledge, the local market in which they operated and the quality of the service they provided but purely by reference to the standard rates that AXA PPP and BUPA were willing to reimburse. In addition, consultants' fees varied depending on the patients' insurer rather than the consultants' own costs or the treatment provided.
- (c) The codes were relatively rigid and did not take into account the level of variation within different procedures, co-morbidities and associated factors.
- (d) A policyholder might wish to pay a top-up fee in order to secure the services of a consultant with particular expertise,<sup>677</sup> which enhanced patient choice and transparency.<sup>678</sup> This would provide an incentive on consultants to develop expertise and compete on quality and did not affect insurers' claims costs.<sup>679</sup>
- (e) Bupa and AXA PPP's restriction on top-up fees led to a reduced choice for patients, and by capping fees, insurers were able to engage in price fixing for all consultants in private practice.<sup>680</sup>

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<sup>674</sup> [AXA PPP response to issues statement](#), Section E. Indeed, most of the PMIs commented on the importance of consultants to their businesses. See the footnote in paragraph 7.94 above on the results of the [CC patient survey](#) and the reasons for choosing privately-funded healthcare.

<sup>675</sup> [AXA PPP response to issues statement](#), Section E.

<sup>676</sup> [FIPO response to issues statement](#).

<sup>677</sup> [BMA response to provisional findings](#), pp2–3. FIPO made similar representations that fee-capping amounted to price fixing—see [response to provisional findings](#), p19.

<sup>678</sup> [PPF response to provisional findings](#), p2.

<sup>679</sup> [BMA response to provisional findings](#), pp2–3.

<sup>680</sup> *ibid*, pp2–3.



- 7.103 Nuffield said that it saw no reason why top-up fees should not be permitted by insurers. Consultants should be able to charge fees that reflected their experience and expertise, provided that any anticipated excess was made known to the patient at the first available opportunity.<sup>681</sup>
- 7.104 There is clear disparity in organizational size between an individual consultant (and indeed most consultant groups) and an insurer. In addition, we find the argument that Bupa recognition and AXA PPP is critical to many consultants persuasive, given Bupa and AXA PPP's share of private patients. Furthermore, a consultant who is not recognized by Bupa and/or AXA PPP or who loses a significant proportion of Bupa referrals because they refuse to agree to be fee-capped could well find it uneconomic to run a private practice. See paragraph 7.75 above in relation to Bupa's ranking of consultants and its promotion of Premier Partner consultants versus other consultants and the criteria it applies for a consultant to be 'plan approved' under open referral policies.
- 7.105 The two largest insurers have been able to agree standard fees without negotiation with a significant number of consultants (and in relation to all new consultants impose a standard fee in order to be recognized). We note that the BMA's recent survey of consultants found that the number of consultants threatened with de-recognition by insurers has risen from 11 per cent in 2011 to 34 per cent in 2012.<sup>682</sup> We also refer to paragraph 7.77 above and the fact that since August 2011 Bupa has asked approximately 10 per cent of its active non-fee-capped consultants to lower their fees, failing which they will be derecognized, almost all of whom have agreed to lower their fees. We consider, therefore that at the very least Bupa and AXA PPP have buyer power in relation to consultants. Consequently, Bupa and AXA PPP's actions in relation, in particular, to capping some consultant fees and the recognition of consultants has the potential to distort competition between consultants.
- 7.106 If extensively and rigidly applied, fee-capping consultants could lead to distortions in competition between consultants and to reduced consumer choice. Fee-capping (and derecognition of consultants who do not agree to abide by the insurer's fee schedule) has the potential to increase the disincentives on consultants from setting fees to reflect their costs, experience, expertise and the local market conditions. This distortion may potentially be increased, the greater the number of insured patients on policies that require open referrals from GPs as policyholders are channelled to lower cost consultants. Moreover, assuming that Bupa continues with its policy of de-recognizing consultants who charge prices which are higher than 90 per cent of their peers (see paragraph 7.77 above) and not recognizing new consultants unless they agree to be fee-capped, this is likely to lead to the majority of consultants being required to charge Bupa's standard national reimbursement fees and the ability of policyholders to pay top-up fees to have a greater choice of consultant significantly limited irrespective of the terms of their policy.
- 7.107 However, we have not received evidence that Bupa's and AXA PPP's contracts with new consultants are leading to the number of new consultants being recognized reducing annually since their introduction.<sup>683</sup> Over the period from 2011 to 2013, we observed no material reductions in the total number of consultants recognized by

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<sup>681</sup> Nuffield response to provisional findings, paragraph 4.3.

<sup>682</sup> <http://bma.org.uk/news-views-analysis/news/2013/april/doctors-fees-increasingly-threatened-by-insurance-companies>.

<sup>683</sup> For example, AXA PPP said that prior to the introduction of fee-capping contracts, it had 22,500 recognized consultants and 1,300 were recognized in 2007. In early 2011, it had 23,000 recognized consultants and 1,300 were newly recognized in that year. In 2012 and 2013, AXA had approximately 24,000 recognized consultants. AXA PPP also said that it monitored carefully the impact of the fee-capping contract to ensure that it maintained adequate choice of consultant for its policyholders. AIS response, paragraph 5.2 et seq. Similarly, Bupa confirmed that it had continued to recognize approximately [§<] new consultants a year since June 2010.

Bupa, with the number of actively billing consultants remaining constant at about 19,000 each year, compared with, according to NAO estimates, approximately 15,750 consultants active in private practice work in 2011/12. Bupa confirmed that it continued to recognize around [X] new consultants annually. The number of consultants recognized by AXA PPP over the period also remained constant, at around 24,000. As discussed in more detail in paragraph 7.116 below, Bupa and AXA PPP have only derecognized 27 and 21 consultants respectively for charging in excess of contracted fee levels since 2011.

- 7.108 We also do not have evidence that the number of consultants in private practice as a whole is being adversely affected by the actions of the insurers, nor that, as a result of the fee-capping of some consultants, consultant fees are being constrained to such a level that this is adversely impacting on consumer choice or quality, discouraging innovation or otherwise causing long-term consumer detriment. We note that FIPO submitted concerns that based on an NAO report, the number of consultants undertaking private practice work has reduced by a third from 2006 to 2012<sup>684</sup> (see paragraph 7.51). However, the NAO report<sup>685</sup> indicates that in 2003, the NHS introduced a new contract for its consultants with a view to improving value for money for taxpayers, including by preventing an increase in private practice work undertaken. Although the proportion of NHS consultants undertaking private work had declined from around two-thirds in 2000 to 39 per cent in 2013, the NAO observed that the absolute number of consultants in private practice had not declined significantly—from 16,349 in 2000 to 15,754 in 2012.<sup>686</sup>
- 7.109 There are clear benefits to policyholders, which should be passed on to consumers, resulting from insurers promoting lower-cost consultants. Moreover, we would anticipate that competition in the insurance market would ensure that the insurers' strategies to contain costs in particular by Bupa and AXA PPP are passed through to policyholders in the form of lower premiums and do not lead to a reduction in innovation or quality. However, FIPO expressed concerns that it should not be presumed that if insurers have buyer power, any gains would be passed on to consumers. Whilst the PMI sector is highly concentrated (see paragraph 3.80), we note that patients insured under corporate trust arrangements benefit directly from reduced consultant costs achieved by the insurers. Similarly, the large corporate sector is highly transparent and competitive, with pricing based on costs incurred by insurers in the previous period which would result in a significant proportion of reduced fees being passed through to such customers. Finally, we note that even a monopolist would pass through a proportion of a reduction in costs achieved.
- 7.110 Moreover, corporate policyholders can relatively easily switch providers if this were to become an issue for their members, in particular as a result of open referral policies and insurance recognition policies. In relation to personal policyholders, we note that at present open referral policies are not generally available. It can be extremely difficult for a personal policyholder to switch insurer and on taking out a policy or at renewal a personal policyholder may not be able readily to understand the implications in terms of consultant choice of an open referral policy or the likely impact of the insurers' consultant fee and recognition policies on choice of consultant at the time of claim. This can be contrasted to the position in relation to hospitals where a policyholder is generally able to identify which hospitals they would most likely want to access and therefore be included in their policies.

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<sup>684</sup> FIPO response to provisional findings, p43.

<sup>685</sup> NAO, Department of Health: *Managing NHS Hospital Consultants*, p17.

<sup>686</sup> *ibid*, p21.

- 7.111 We also recognize that whilst the insurers encourage policyholders to see fee-capped or fee-assured consultants, policyholders—with the exception of those that hold open referral policies—can pay top-up fees under the terms of their policies if they wish to see any recognized consultant. Whilst policies that require open referral are a standard option for Bupa corporate policies (although not all corporate policies have open referral) and Bupa is considering whether to offer such policies to personal customers more widely, policyholders will continue to be able to choose between policies offered by Bupa and other insurers where open referral is not mandatory and under which policyholders are able to pay, and are not prevented from paying, top-up fees if they so choose. In relation to Bupa, the majority of policyholders and almost all personal policyholders are not required to obtain pre-authorization before seeing a consultant and are able to see any recognized consultant under the terms of their policies. It is only policyholders on open referral policies whose choice of consultant is more limited and who are required to obtain pre-authorization before seeing a consultant. However, as noted previously, such policyholders currently have access to over 90 per cent of recognized consultants.
- 7.112 We therefore do not find that insurer buyer power in relation to consultants has an adverse effect on the provision of consultant services in the UK. However, see our comments below in paragraph 7.135 with regard to the nature of information provided to policyholders and to consultants and the potential this may have to distort competition between consultants and limit patient choice causing long-term detriment.

### ***Other issues with regard to insurers and consultants***

- 7.113 Other main criticisms of insurers' conduct we received fall into the following categories:
- (a) providing misleading information to patients on the status of consultants and/or their level of charges;
  - (b) misleading patients over the reasons for redirecting patients from one consultant to another and the basis on which the insurer recommends one consultant rather than another;
  - (c) lack of transparency to both patients and consultants as to the insurer's criteria for recommending particular consultants over other consultants;
  - (d) arbitrary de-recognition of consultants and a lack of transparency in insurers' handling of such matters;
  - (e) without notice or consultation imposing additional obligations on consultants to continue to be recognized;
  - (f) inappropriate clinical referrals by insurers to consultants for certain procedures;
  - (g) using staff who lack appropriate medical qualifications to review proposed treatments or provide advice on medical matters;
  - (h) requiring particular courses of treatment, for example that all musculoskeletal cases be referred to a physiotherapist in the first instance rather than a consultant irrespective of GP referral or requiring the consultant's proposed course of treatment to be reviewed by the insurer prior to authorization; and
  - (i) changing benefits of policyholders mid-term or withdrawing authorization mid-treatment.

- 7.114 As noted previously, Appendix 7.3 sets out in more detail the key themes emerging from the submissions we have received from consultants in the course of the investigation, including in response to the provisional findings.
- 7.115 Most of the complaints that we received relate to Bupa, with some relating to AXA PPP and other insurers. This is unsurprising, given the fact that Bupa's reimbursement rates are generally regarded as the benchmark for consultant charges and that it has been at the forefront of a number of these initiatives, in particular the review of its reimbursement levels, fee-capping of outpatient consultations as well as surgical procedures and open referral as described elsewhere in this section. As noted elsewhere, Bupa is also considering extending these initiatives in the near future, in the case of open referral, potentially to more personal customers and, in the case of fee-capping, to more consultants.<sup>687</sup> The issues that appeared to generate most submissions from consultants and trade associations included de-recognition of consultants, insurers restricting choice of consultants and authorization of treatment and providing misleading information as to why a policyholder was directed to one consultant over another.
- 7.116 In response to concerns raised by consultants and trade associations, we sought further information from the four major insurers about the number of consultants that had been derecognized over the period from 2011 to 2013 and associated reasons. As shown by Table 7.2 below, typically a small proportion of consultants have been derecognized over the period—in the context of each of the major insurers recognizing in excess of 20,000 consultants in total compared with an NAO estimate of 15,754 consultants in private practice in 2011/12. Each of the major insurers indicated that very few of its consultants had been derecognized as a result of fees alone.<sup>688</sup> Although 4,608<sup>689</sup> consultants were derecognized by Bupa over the period, as explained previously only 27 were as a result of consultants persistently billing above 90 per cent of their peers when no justification was given. Bupa's explanation for the sharp increase in the number of consultants derecognized between 2011 and 2013 was due to it contacting and removing consultants that were not actively billing in preparation for the launch of its 'Finder Tool' search engine. It also said that improved use of GMC data resulted in an increase in the number of de-recognitions where a consultant's GMC licence was lost or lapsed or where the GMC had raised serious concerns about a consultant's practice. Based on data submitted by Bupa, around 4,500 consultants were derecognised over the period due to these factors. No consultants recognized prior to 2010 were derecognized for charging above its reimbursement rates.
- 7.117 AXA PPP derecognized 21 consultants for failing to charge within contracted fee schedules, while PruHealth had derecognized only four for failure to reach a mutually acceptable fee agreement. Although Aviva derecognized a total of 364 consultants over the period, all but four of those were derecognized due to changes in their status on the GMC register.

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<sup>687</sup> See paragraphs 7.50 & 7.54 above.

<sup>688</sup> A decision to derecognize may be informed by a range of factors including clinical issues; restrictions imposed by the GMC; irregular fraudulent billing practices, misleading billing practices; and/or failing to bill in accordance with a fee-capped contract.

<sup>689</sup> Bupa submitted that the vast majority of de-recognitions were due to administrative reasons, or issues surrounding registration and licensing with the GMC.

TABLE 7.2 Number of consultants derecognized by main insurers for any reason, 2011 to 2013

PMI	2011	2012	2013	Total
Bupa	320*	2,773*	1,488*	4,608*
AXA	20	15	15	50
Aviva	N/A	N/A	N/A	364
PruHealth	N/A	N/A	N/A	18

Source: Parties.

\*Please see the explanation for the change in Bupa's figures above at paragraph 7.116.

- 7.118 In terms of the issues raised by consultants about insurers refusing to authorize patients' choice of consultant or recommended course of treatment, AXA PPP submitted that other than for corporate policyholders on Pathways plans, policyholders could see any consultant recognized by AXA PPP for eligible treatment. Corporate policyholders on its Pathways plans have access to approximately 22,000 consultants. The only circumstances where customers may be denied authorization for a particular course of treatment are those falling outside its cover, such as cosmetic treatment, fertility treatment, unproven treatments or pre-existing conditions.
- 7.119 With the exception of open referral policyholders who are restricted to using plan-approved consultants, as discussed previously,<sup>690</sup> Bupa policyholders may see a consultant of their choice. In respect of treatments, only treatments that are within the scope of the eligible treatments identified in a member's insurance policy will be authorized. A treatment is also not eligible if the specific clinical indication for carrying it out is not supported by scientific evidence or in line with generally accepted medical practice, such as published evidence based guidelines. This is sometimes identified through a medical review process. From 2011 to 2013, Bupa has refused to authorize treatment of between [X] and [X] per cent of requests each year, and approximately [X] per cent of claims for payment have been denied.
- 7.120 We have described in paragraphs 7.74 to 7.80 the different types of consultants recognized by the major insurers including the nature of Bupa's scoring system for recommending consultants to its policyholders. Bupa confirmed that any recognized consultant could contact it to enquire about their relative rankings and for clarity as to how Bupa's scoring system operated.

### **Conclusion—other issues concerning insurers**

- 7.121 We have not received persuasive evidence that these issues indicate a competition problem in the provision of consultant services. As described above, derecognition levels are low. All the major insurers recognize the vast majority of consultants in private practice and the vast majority of policyholders have access to all such recognized consultants. Even policyholders on Bupa's open referral policy have access to over 90 per cent of its recognized consultants. Similarly, the evidence we have received regarding treatment authorizations does not suggest that the insurers are restricting access to consultants or treatments so as to give rise to an AEC.
- 7.122 However, we recognize the level of concerns expressed by consultants and their trade associations and we consider that this raises important issues with regard to effective communication by the insurers of their strategies to consultants given the critical role consultants play in facilitating choice and quality and innovation in the

<sup>690</sup> See further paragraph 7.78 above. In return for a lower-cost premium, open referral policyholders must see a plan-approved consultant from a smaller pool of Bupa consultants (approximately 90 per cent of Bupa's recognized consultants).

sector. Insurers increasingly determine not only fee levels but also which consultants a patient may see. Depending on how rigidly and extensively they implement standard national fees, direct policyholders and fee-cap consultants, this could lead to a shortage of consultants and/or a reduction in quality and innovation.

- 7.123 It is essential that patients are provided by the insurers with accurate information regarding a consultant's fee levels and the quality of the services a consultant provides. In the light of the factors referred to in paragraph 7.104 above regarding the large insurers, consultants need to be clearly informed as to why they are not being recommended to patients and/or why their fees are not being reimbursed. Material and sudden changes to a consultant's reimbursement levels or flow of patients has the potential to affect significantly the viability of a consultant's practice. Consultants need and should be provided with some certainty over reimbursement levels and sufficient advance notice of changes to enable them to alter their practice accordingly or seek to negotiate higher fees in an orderly and transparent way with the insurer. We have also received some evidence that consultants are not given notice, or only given very short notice, of changes to reimbursement levels which in some cases are material changes, or have had difficulties in obtaining responses from the insurers to concerns raised.
- 7.124 We have received some evidence that some of the language used by insurers in distinguishing between consultants who are recognized but not fee-capped may suggest to patients that a consultant who is not fee-capped overcharges for their services. Similarly, we have received some evidence to suggest that some patients understand that quality rather than primarily cost (together with location and specialty) are the driving factors for the insurers' recommendations and that a consultant to whom a patient has been referred but who is not fee-assured may provide a lower quality of care than one who is recommended by the insurer.
- 7.125 To the extent to which initiatives such as open referral achieve the insurers' objectives of lowering costs and these are passed on to policyholders in the form of lower premiums, this will be beneficial to consumers. If they are unsuccessful in reducing premiums, we have no evidence to suggest that in particular the corporate sector, where many of these initiatives have been launched, will not respond accordingly.
- 7.126 In respect of the concerns that insurers are changing benefits of policyholders' mid-term or withdrawing authorization mid-treatment, this is a concern, but a matter for the Financial Ombudsman Service (FOS) to address. Whilst outside our terms of reference, it is in relation to this issue that we received the most complaints from policyholders. It is clearly important that policyholders understand the terms of their policies at purchase and renewal. This includes being made aware and fully informed about changes to reimbursement rates and the recognition of consultants which has a direct impact on the nature of and value of benefits available under their policies.

### ***Summary of our findings on consultants***

- 7.127 We have found that there are factors which would indicate that some individual consultants and some consultant groups in some local markets may have market power. However, the evidence we have received and reviewed does not show that any such local market power by individual consultants is giving rise to competitive harm. Therefore, on the basis of the available evidence, we did not find that any local market power by individual consultants gave rise to an AEC in any local market for any specialty in the UK. However, we also assess in Section 8 clinician incentives, as well as in Section 9 the lack of information and information asymmetries in relation to consultants.

- 7.128 The formation of consultant groups as in other professions of itself cannot be presumed to be harmful to competition. The price analysis carried out at the local level on six anaesthetist groups which set prices and which were identified as having high local shares of supply and as being of concern to insurers showed some evidence of price effects in one case, mixed evidence in two cases and no price effects in the other three. In our view, the results of the pricing analysis and the difficulties in obtaining data on anaesthetist groups did not justify pursuing this line of inquiry. Similarly, in relation to other consultant groups, given the limited evidence on such groups and the results of the price analysis in relation to anaesthetist groups, we did not consider that a detailed assessment of any particular consultant group in any local area would be justified.
- 7.129 The evidence we have analysed does not indicate that the formation of anaesthetist groups or other consultant groups in general have a widespread adverse effect on competition. In addition, the evidence does not lead us to conclude that the formation of any individual anaesthetist group or other consultant group adversely affects competition in any local market. As stated above, the formation of groups may give rise to competition benefits. However, we also note that, having regard to the relevant provisions on anti-trust enforcement, and depending on the particular circumstances of the individual arrangements in point, certain practices may be contrary to such competition provisions.
- 7.130 The two largest insurers at least, Bupa and AXA PPP, have significant buyer power, but we have found insufficient evidence that currently it is being exercised in such a way as to harm competition by suppressing fees to uneconomic levels resulting in a shortage of consultants in private practice or to a reduction in innovation or quality of consultant services. Indeed, the incentive is on insurers to promote competition among consultants on price and quality and maintain innovation and quality to protect and indeed improve demand for PMI.
- 7.131 In relation to fee-capping specifically, we consider that, on balance, the evidence we have received does not demonstrate that, at present, Bupa—or indeed any other insurer—is distorting competition between consultants by imposing fee-capping, in particular on newly-recognized consultants, as a condition for recognition. Evidence we obtained from the major insurers did not reveal any material changes in the total number of consultants recognized, or new consultants recognized each year since 2011. We also observed that only a small number of Bupa and AXA PPP recognized consultants had been derecognized for failing to charge within contracted rates (whether fee-capped or not). Similarly, evidence regarding de-recognition of consultants more generally from the insurers does not suggest that quality or innovation is being adversely affected at present by these initiatives.
- 7.132 There are clear benefits to policyholders in insurers promoting lower-cost consultants which should be passed on to their policyholders in the form of lower premiums. We have some concerns that if fee-capping is rigidly and extensively applied, competition between consultants could be distorted as the fee levels adopted by Bupa and AXA PPP, whilst maximum fees are in practice actual fee levels and are uniform fees and therefore do not take into account a consultant's degree of specialism, patient mix, experience or geographic location. There is also the risk that without transparent and fair review mechanisms and flexibility in application, uniform fees could lead to a distortion of competition between consultants and an adverse effect on quality and innovation.
- 7.133 Whilst all policyholders are able to pay top-up fees under the terms of their policies and all insurers including Bupa and AXA PPP offer policies to both corporate and personal policyholders that do not require open referral, the ability to pay top-up fees

and the choice this provides policyholders is dependent upon the insurers' consultant recognition policy. Moreover, the more patients are directed to fee-capped consultants by the insurers irrespective of the terms of a policyholder's policy, this could impact on the viability of private practice for some consultants.

- 7.134 As noted above, it is not in the insurers' interests to exercise their buyer power in such a way as to harm competition in the provision of consultant services. Whilst we have not received persuasive evidence that the other issues raised by consultants and trade associations in relation to insurers indicate a current competition problem in the provision of consultant services, we consider that insurers, and in particular Bupa, as they increase their role in directing patients to consultants, need to ensure that their policyholders are provided with clear and accurate information about the terms of their policies. Similarly, they need to ensure that their interaction with consultants is fair and transparent to enable consultants to manage effectively their practices and effectively treat patients.
- 7.135 The availability of information on consultant performance and fees is considered further in Section 9. As set out in Section 9, we consider that with greater availability of information on consultant performance and fees, this will increase competition between consultants and lead to patients being able to make more effective choices. This may address some of the issues that have led to insurers adopting the type of strategies considered in this section and may ensure that these strategies are not rigidly and extensively applied with the consequent risks to, in particular, quality or innovation.



## 8. Hospital competition for clinician referrals

### *Introduction*

- 8.1 One of the ways that private hospitals attract business is by providing benefits and adopting schemes to encourage consultants to treat private patients at or commission tests from their facilities. As most patients are referred to consultants by GPs, hospitals may also try to encourage GPs through incentives to refer patients to consultants who use their facilities.
- 8.2 Private hospitals encourage consultants to use their facilities in a variety of ways. For instance, they promote themselves to consultants, GPs and other clinicians in communications or at events, in or at which they set out the benefits of using their facilities including any financial benefits of doing so. They commonly offer access to resources which will make using their facilities more convenient for a clinician by, for example, making parking spaces, consulting rooms and/or secretarial services available at low or no cost. They may also operate schemes which expressly commit consultants to undertake a proportion of their work at their facilities in return for financial benefits or which provide them with financial incentives to do so even if there is no express obligation.
- 8.3 In Section 6 we considered the extent to which benefits and incentives offered to hospital operators may constitute barriers to entry and expansion. In this section, we first describe the benefits and incentives offered to clinicians and then we assess the extent to which such arrangements may distort competition between private hospital operators.

### *Schemes adopted by the main hospital groups*

#### *The evidence we collected*

- 8.4 Our market questionnaire asked private hospital operators what schemes they operated to encourage consultants to treat patients at or commission tests from their facilities, or to encourage GPs to refer patients to consultants who practised there. We asked for details of these schemes including when they operated, the cost of operating them, who benefited from them, and the value of the rewards to which they entitled clinicians. We reviewed internal documents setting out the business rationale for these schemes and, in the case of equity partnership arrangements or joint ventures, we examined the obligations of the parties as set out in the legal agreements giving effect to or accompanying them. In addition, as part of the research for our case studies in Bath, Edinburgh and central London, we looked at the use of such schemes by entrants and incumbents during episodes of entry and expansion.
- 8.5 We invited the views of PMIs, consultants', GPs' and other clinicians' representative and professional bodies on such schemes and the effect that they have on competition between hospitals. In addition, in our survey of consultants we asked questions relating to their knowledge and experience of such schemes.
- 8.6 We reviewed the regulatory framework within which these schemes operate in the UK, principally the GMC's *Good Medical Practice*<sup>691</sup> and its associated guidance. We also reviewed the regulatory framework governing clinician incentives in the USA, Canada and Australia.

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<sup>691</sup> [Good Medical Practice](#), GMC, 2013.

- 8.7 We describe below current or recent schemes adopted by the main hospital groups to encourage referrals by GPs to consultants practising at their hospitals and to encourage consultants to treat patients at or commission tests from their hospitals. We then go on to describe schemes operated by some of the smaller hospital operators, details of which were either collected during the research for our case studies on market entry or from submissions made by the parties. Whilst we have focused our enquiries on schemes available to GPs and consultants as these are the most relevant given the primary role of GPs as a source of referrals and the importance of consultants to a private hospitals business, other clinicians who refer patients may also be offered such schemes.

## **BMI**

### **GPs**

- 8.8 BMI told us that, currently, it only made payments to GPs for private GP services provided in its hospitals, ie BMI subcontracted services to GPs and paid them for those services. It said that it had considered GP incentive schemes in the past but had decided not to implement these proposals following legal review.
- 8.9 BMI operated a pilot arrangement in Bath, in 2010, whereby it made payments to GPs for preoperative assessments on BMI patients. It told us that the programme was designed to increase patient referrals through improved patient service by making pre-assessment more convenient. Under the terms of the scheme, where patients were referred to the Bath Clinic for an outpatient consultation, and it was determined that surgery was necessary, a preoperative assessment (which would otherwise be carried out at the Bath Clinic) was booked with the referring GP. The GP would be paid according to the type of assessment undertaken, with payment dependent on the patient completing their care pathway at the Bath Clinic. Between six and eight local GP surgeries joined the scheme.
- 8.10 We asked hospital operators whether they had, in the last six years, any arrangements in place whereby GPs or other primary care providers would prioritize referrals to their facilities. BMI told us that it previously had in place an arrangement with [REDACTED].
- 8.11 It told us that it also had in place an arrangement, no longer active, with [REDACTED].
- 8.12 BMI told us that it had operated the BMI Syon Clinic as a corporate joint venture (ie a separate company) with Sentosa, a company comprising primarily consultants and GP shareholders. The Syon Clinic offers diagnostic and outpatient facilities provided by the consultants based there. [REDACTED], Sentosa consultants at the Syon Clinic referred all their patients from the Syon Clinic requiring in-patient care to BMI facilities and, where tests could not be undertaken at the clinic, to a BMI facility, subject to the GMC rules on *Good Medical Practice*. BMI told us that the corporate joint venture with Sentosa, which had established the BMI Syon Clinic, had helped move work from [REDACTED].
- 8.13 We asked hospital operators for details of any assets that they owned or rented where GPs or other primary care providers practised. BMI gave us examples of such arrangements, mainly operated at its hospitals, and told us that, in addition, it had some BMI outpatient facilities in GP surgeries.

## Consultants

- 8.14 BMI told us that in early 2012, before the OFT's reference decision, it had considered its position in relation to consultant incentive schemes. It wished to ensure that it was not engaging in schemes that could make the company vulnerable to media or regulator criticism, notwithstanding the eventual view that the CC took on the merits or demerits of these schemes. It decided to stop direct financial incentive schemes and profit-share arrangements, including the 'consultant loyalty schemes' we describe below, other than where, it said, these related to joint investment or similar arrangements between the consultant and the hospital. Nonetheless, BMI told us that in an environment where competition for consultants was fierce and consultants represented a significant source of work, legitimate grounds arguably did exist for payments to consultants by hospitals. It noted that it had not withdrawn from consultant arrangements that directly supported investment in particular joint ventures or co-investment vehicles.<sup>692</sup> BMI said that it did not consider these to be 'incentives' at all; rather, they were necessary pro-competitive terms to support hospital investment and to bring into existence a shared desire between consultants and hospitals to develop new and enhanced patient services.
- 8.15 BMI supplied the CC with a review of what it described as 'Consultant Loyalty Schemes' that it said had been prepared as part of its business operations in 2007 (ie not in the context of the CC investigation) which contained recommendations for the introduction of schemes at two of its hospitals, which it considered as being under the most immediate and direct threat from competitive entry.
- 8.16 This 2007 review was part of its strategic response to increased competition from other hospital operators, including Circle. A board paper of April 2007, a month after Circle obtained planning permission for its Bath hospital, assessed the severity of the competitive threat to each of its hospitals. Mt Alvernia (Guildford) and Bath were considered to be exposed to the highest risks and, accordingly, were proposed as the first hospitals where consultant loyalty schemes would be set up.
- 8.17 The 'Mark 1' scheme combined profit sharing and 'virtual equity' elements which aimed to engage and motivate current and future consultants 'to fully commit to the Bath Clinic and to be rewarded for the future, for contributing to sustained growth over a period of time'. The scheme was designed in part to mimic an equity share plan which would have been impossible to implement at BMI given its ownership structure.
- 8.18 The scheme covered a six-year period and entitled consultants to a share of the Bath Clinic's profits, the size of their entitlement being determined by the amount of revenue that a consultant brought to the hospital.<sup>693</sup> A 'standard' member would be entitled to a [§] per cent share of the Bath Clinic's profits with an [§] being paid into the consultant's 'pot' which would pay out at the end of the scheme. A 'Platinum' member would be entitled to [§] per cent of the Bath Clinic's profits.
- 8.19 As well as the rolling share of the Bath Clinic's profits and the long-term payment referred to above, consultants would be entitled, depending upon their level of membership, to receive some or all of: [§]
- 8.20 In addition to these benefits, if a member were to introduce a new consultant to the Bath Clinic who subsequently went on to enter into a similar agreement, then the

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<sup>692</sup> For example, it told us that BMI Beardwood invested in a new cancer treatment centre through a joint venture with a number of consultants [§].

<sup>693</sup> [§]

introducing member/consultant would be entitled to receive an additional profit share equal to the new consultant's profit share in the first year.

8.21 The 'Mark 1' scheme was contractual. The contract required a consultant 'to operate his private medical practice predominantly at the Hospital (the Bath Clinic) for the duration of this agreement'. In addition, the consultant was required to warrant that he had not, from the date of the agreement, entered into any agreement with any competitor in which he had:

- (a) a financial interest; or
- (b) profit share; or
- (c) any beneficial interest in equity or otherwise.

8.22 Consultants were also required to agree that they would not enter into any form of agreement or contract with any competitor relating to the operation of a private medical practice, including acquiring any financial interest in such a competitor, although they could retain practising privileges elsewhere.

8.23 The Mark 2 scheme was adopted in 2010 and would pay out if consultants brought in [redacted] per cent or more of the revenue they had brought to the Clinic in 2009. The size of the entitlement would vary with the amount of extra revenue that the consultant brought in over and above the [redacted] per cent 'baseline'. For growth of up to £[redacted] above the baseline, the consultant would be entitled to [redacted] per cent of the growth up to a maximum of [redacted] per cent for growth of £[redacted].

8.24 There was, unlike Mark 1, no formal contract with consultants, but participating consultants were expected to sign a confidentiality agreement. The Mark 2 scheme also differed from Mark 1 in that there were no bars to participation, such as financial interest in a competitor.

8.25 BMI told us<sup>694</sup> that it had [redacted].

#### *Cost of the schemes*

8.26 We show below the payouts from the Mount Alvernia and Bath Clinic schemes.

TABLE 8.1 Consultant loyalty scheme payouts at Mount Alvernia and Bath clinic

	£		
	FY10	FY11	FY12 estimate
Mount Alvernia*	[redacted]	[redacted]	[redacted]
<i>Bath</i>			
Mk1	[redacted]	[redacted]	[redacted]
Mk2	[redacted]	[redacted]	[redacted]
Total	[redacted]	[redacted]	[redacted]

Source: BMI.

\*A breakdown between the Mk 1 and 2 schemes at Mt Alvernia was not available.

<sup>694</sup> BMI response to provisional decision on remedies, 7 February 2014, Appendix 8, paragraph 2.1.

## Spire

### GPs

- 8.27 Spire told us that GPs should never be incentivized, directly or indirectly, by private hospital operators, PMIs or consultants to make referrals to a hospital. It said that several Spire hospitals had agreements with GPs for the provision of services of various sorts, including advising on marketing to GPs and health screening, room rental for consultants visiting GP practices and facilities for advertising the relevant Spire hospital. Spire provided us with a list of these services and where they had been put in place.

### Consultants

- 8.28 Spire told us that it had no schemes providing incentives to consultants as it would define such schemes, either at a national or at individual hospital level, and to the extent that arrangements might exist which might be considered as offering such incentives these would have been negotiated between the consultant and the relevant hospital director, may have arisen out of custom and practice and may not necessarily be recorded in writing.
- 8.29 Spire noted that arrangements with consultants could also sometimes take the form of joint ventures to introduce or expand a new procedure, service practice area or, as in the case of Spire Brighton, extend to the establishment of a new hospital.
- 8.30 It told us that Spire Brighton (the Montefiore Hospital) was operated by a joint venture company (Montefiore House Limited). Spire had subscribed £[redacted] in equity in return for which it had received a [redacted] per cent share of Montefiore and the group of orthopaedic consultants and physiotherapists had subscribed £[redacted] in equity in return for which they would receive a [redacted] per cent share of Montefiore. The shareholders agreement committed the consultants to refer their private patients to the hospital for five years from hospital opening, subject to the rules and recommendations in *Good Medical Practice* and the best interests and needs of the patient.
- 8.31 Spire listed the schemes that it operated and told us that most of them involved discounted consulting room rental or secretarial fees which it said were not linked to the volume or value of business that the consultant brought to the hospital, nor to the proportion of their work that was undertaken at a Spire hospital.
- 8.32 We examined the arrangements that Spire set out in its response to our market questionnaire. At Spire's [redacted] hospital, for example, the majority of the arrangements listed related to discounted room rentals and secretarial services. Some, however, involved quite significant payments to consultants.
- 8.33 Under one arrangement, the hospital paid the medical defence organization<sup>695</sup> costs of a surgeon, as well as providing the surgeon with free medical secretarial services and consulting rooms. The payment of the consultant's professional indemnity insurance costs, Spire told us, was in return for the consultant committing his practice and referrals to the hospital. This arrangement was subject to such referrals being in the clinical interests of the patient, in compliance with applicable codes of practice of the BMA and GMC and other than where a patient's insurer does not recognize the Spire

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<sup>695</sup> Medical defence organizations provide doctors operating in the private sector with indemnity cover in the event that they are sued for negligence.

hospital for care, diagnosis or treatment. Spire told us that the annual value of payments to this consultant between 2009 and 2012 had amounted to £[REDACTED].

- 8.34 Another scheme [REDACTED] paid three consultants a proportion of the profit made by the hospital from cardiology tests referred to the hospital by the consultants. In 2011, this scheme paid out just over £[REDACTED] to each of the consultants. Spire told us that this arrangement pre-dated its ownership of the hospital [REDACTED].
- 8.35 Spire told us that in a small number of cases a consultant or small group of consultants had agreed to base their private practice exclusively at a particular Spire hospital in order jointly to develop a practice or new specialty in a local area (and subject to the regulatory requirements of the GMC). At its Southampton hospital, for example, it had established the Mosaic Orthopaedic Centre,<sup>696</sup> equipped with outpatient consulting rooms, a CT scanning and MRI suite and two operating theatres with laminar flow. Spire pays the Mosaic group a fee based on the revenue generated by the Mosaic consultants. It told us that its total payments since January 2009 to Mosaic amounted to £[REDACTED].
- 8.36 Spire told us that the agreement with the Mosaic consultants provided carve-outs for them to treat patients elsewhere if so required by the GMC guidelines or if the patient expressly wished to be treated elsewhere.
- 8.37 Similarly, it told us that it had acquired the orthopaedic surgery practice of [REDACTED] whose private practice work was exclusive to [REDACTED] for a limited period and who referred private patients to the hospital 'subject to the patient's clinical best interests, patient choice and recognition of the facility by the patient's PMI'. Between 2010 and the first half of 2012, payments to [REDACTED] amounted to just less than £[REDACTED] based on the share of the revenue generated by his practice and that of his colleague in the [REDACTED] unit [REDACTED].

## HCA

### GPs

- 8.38 HCA provided us with a description of the arrangements each of its hospitals has with GPs where these exist.
- 8.39 HCA told us that it had a three-year Fully Managed Practice (FMP)<sup>697</sup> agreement with [REDACTED] to provide professional medical services at its Wellington Hospital in return for which he was paid £[REDACTED] also has an equity stake in the Wellington Diagnostic and Outpatient Centre (WDOC) JV in Golders Green.<sup>698</sup> HCA said that the payments to [REDACTED] represented fair market value for the services that he provided to the WDOC.
- 8.40 Also at the Wellington Hospital, HCA has a recruitment agreement with [REDACTED] for the establishment of a private GP practice at the Wellington Hospital. HCA offered [REDACTED] an income guarantee in the form of a loan to facilitate switching [REDACTED] practice to the Wellington Hospital's Platinum Medical Centre. In the event, since [REDACTED] income has not fallen below the guaranteed level, this facility has not been drawn down.
- 8.41 The Harley Street Clinic pays a retainer of £[REDACTED] per year to [REDACTED] under a Professional Services Agreement in [REDACTED] capacity as [REDACTED] New Malden Diagnostic Centre.

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<sup>696</sup> The Mosaic consultants operate outpatient clinics at the Wessex Nuffield and the BMI Winchester hospitals and at Boyd Physiotherapy.

<sup>697</sup> We explain FMPs and the other agreements used by HCA more fully in our discussion of HCA's arrangements with consultants.

<sup>698</sup> Twenty-five private GPs operate from the WDOC: [www.wellingtondiagnosticscentre.com/](http://www.wellingtondiagnosticscentre.com/).

- 8.42 HCA told us that although these types of arrangements originally included obligations upon doctors to use their best endeavours to refer patients to HCA facilities, following a review in 2011/12 contracts were reworded so as to remove this obligation and make clear that doctors, having signed a Professional Services Agreement (PSA), for example, 'shall be under no obligation to refer patients to any [HCA] hospital'.
- 8.43 HCA also has a number of Consulting Room Licence Agreements (CRLAs) with GPs who operate their practices at HCA facilities. It told us that consulting rooms were licensed out at the WDOC and Platinum Medical Centre and that consulting rooms were licensed to two GPs at the Harley Street Clinic Diagnostic Centre. The Lister Hospital owns two facilities where it licenses consulting rooms to GPs (the Chelsea Consulting Rooms and the Chelsea Medical Centre), the London Bridge Hospital provides facilities for two GPs at its Medical Centre in Sevenoaks and for one at the City of London Medical Centre and the Princess Grace Hospital provides facilities for four GPs in a facility located in front of the hospital.
- 8.44 In addition to arrangements between individual GPs and hospitals, HCA, as discussed elsewhere, owns three facilities offering private GP services, including Roodlane Medical Limited and Blossoms Healthcare LLP. Although the agreements originally included referral obligations, HCA told us that the agreements had been varied and since April 2012 no longer included any referral obligations towards HCA facilities.
- 8.45 Finally, HCA told us that it employed four GP Liaison Managers, one for each of the London Bridge, Lister and Wellington hospitals and one for the 'Tristar' hospitals (the Portland, the Harley Street Clinic and the Princess Grace hospital). In 2008, HCA spent £[redacted] million on GP liaison services across its hospitals, in 2009 this figure was £[redacted] million and in 2010 HCA spent £[redacted] million on GP liaison. Such expenditure included expenditure on seminars, training sessions for GP staff and providing information about HCA's services to GPs, practice staff and members of the public as well as some corporate entertaining and social events. Examples include:
- GP breakfast seminars (about 35 such events per year) at the Lister for a total annual cost of £[redacted];
  - consultant/GP summer and Christmas parties at the Lister Hospital for a total annual cost of £[redacted];
  - Basic Life Support and other educational training for practice staff at Tristar for an approximate annual cost of £[redacted] based on two sessions per month for 12 GPs each; and
  - GP mailing regarding new services (usually three times a year) at Tristar for a cost of about £[redacted] each.
- Expenditure on GP liaison at the Wellington Hospital in 2011 was £[redacted] million and at the London Bridge £[redacted].<sup>699</sup>

### *Consultants*

- 8.46 HCA told us that it had six types of agreement that it could offer consultants. Under its CRLA, which had a maximum term of one year and a one-month notice period on either side, consultants were provided with consulting rooms at HCA facilities for

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<sup>699</sup> HCA did not provide 2011 expenditure for the Tristar group.

which the consultant paid a 'fair market value' other than in circumstances such as a consultant coming new to HCA, in which case the fee might be waived for up to six months. It said that less than half of the 3,000 consultants with practising privileges at HCA facilities had CRLAs, which, it noted, contained no obligations on consultants to refer patients to HCA facilities. Consulting room licences may be terminated by HCA, or by the consultant, at one month's notice.

- 8.47 FMP agreements, it said, related to clinical units which HCA wished to establish, develop or strengthen. Consultants were paid a fixed annual fee for their services and, though HCA and the consultants might agree certain growth targets for the unit, no bonuses were payable if they were met. Under the current contract, consultants were not obliged to refer patients to HCA facilities but must always refer on the basis of the patient's best interests and, in line with the draft FMP Handbook, must disclose their financial interests to patients. HCA told us that it had entered into 28 FMPs covering around 130 consultants and 21 of the 28 agreements contained growth plans.
- 8.48 Professional service agreements (PSAs) are agreements between HCA and a consultant for the provision of clinical services, for example a medical directorship at an HCA hospital. Consultants are paid a fixed annual fee for their services based on an hourly rate and the number of hours that the consultant is expected to devote to the work involved. Again, under the current contract consultants are not required to refer patients to HCA hospitals. HCA gave an example of this type of agreement whereby a consultant was to supply neurology services at the Harley Street Clinic with an annual growth target of 10 per cent in new outpatients. HCA has entered into 141 PSAs covering around 170 consultants.
- 8.49 Recruitment agreements (RAs) have the objective of attracting consultants to an HCA facility. The consultant is expected to work with HCA to manage and grow their practice at an HCA hospital. HCA told us that these agreements might be offered to consultants relocating their practices and thus facing increased costs or risking losing patients, consultants in their first year of private practice and consultants wishing to reduce their NHS workload in favour of private practice. Under these agreements HCA may offer the consultant an income guarantee or a loan to cover start-up expenditure. Only ten such agreements are in place and HCA told us that it was in the process of phasing them out.
- 8.50 Recruiting agreements are different from 'recruitment agreements' and provide consultants who already have an FMP with additional resources to attract new or junior consultants to assist the consultant in developing the unit concerned. HCA may provide the consultant with a loan which he or she may use to fund an income guarantee for the new consultant, for example. HCA has 12 such agreements in place.
- 8.51 Galen consultant agreements (GCAs) are agreements between Galen Health Partners (a wholly-owned subsidiary of HCA) and consultants or a company of consultants under which Galen procures certain support services on behalf of consultants such as practice management, practice marketing and financial services. HCA currently has 143 Galen agreements in place.
- 8.52 The number and cost of these various arrangements was set out in HCA's 2012 business plan (2011). In total these costs amounted to around £5 million a year.



FIGURE 8.1

### HCA's consultant engagement schemes



Source: HCA.

- 8.53 HCA told us that in 2011/12 it reviewed its contracts with consultants for compliance with the Bribery Act and GMC guidelines. It told us that these (original) contracts obliged consultants to use their best endeavours to refer patients to HCA facilities but always subject to the clinical needs and best interests of the patient.
- 8.54 However, HCA told us that it wished to remove any potential conflict of interest and so reworded its contracts to state explicitly that consultants party to the agreements we have summarized above were under no obligation to refer patients to HCA hospitals. Letters to doctors explaining the need for the changed wording and also obliging doctors to disclose to patients their financial interest in the unit were sent out in the first half of 2012.
- 8.55 HCA told us that in addition to these arrangements it had entered into a number of JV agreements with consultants for certain outpatient facilities. The model for these JVs was that HCA would obtain a suitable site for the clinic and sublet it to the limited liability partnership (LLP). HCA would provide management services to the LLP in return for a fee of [REDACTED] and the LLP would charge consultants a fee for the use of consulting rooms. In all cases, HCA was the majority owner of the LLP with shares ranging from 51.5 per cent (the Chelsea Outpatient Centre) to 90.4 per cent (the LOC Partnership LLP), with the remainder being owned by consultants practising at the facility.
- 8.56 The original agreements underlying these arrangements included obligations as regards referrals to HCA hospitals, though with caveats with reference to patients' best interests.
- 8.57 The 2011 LLP agreement for the LOC obliged members to use their reasonable endeavours to refer their own patients who were seen at the LOC and who required inpatient care to HCA facilities, 'subject always to the patient's clinical needs and best interests'.
- 8.58 The LLP agreement relating to the Chelsea Outpatient Centre LLP similarly obliged members to 'use best endeavours to refer all patients of the Member, who are seen at the Centre and who require in-patient treatment to an HCA hospital subject always to the clinical and best needs of the patient'.
- 8.59 HCA told us that just as it had reviewed its service agreements for compliance with the Bribery Act and GMC guidelines, it did so for its JV agreements. As a result of this review, the 'best endeavours' obligation to use HCA facilities wording was changed so that members undertook not to be influenced by the terms or the existence of the JV agreement in their choice of treatment or treatment facility recommended to patients.
- 8.60 We note that the varied agreement does include an undertaking that the member will 'use his reasonable endeavours to utilise the facilities of the Centre for the purpose of developing his private practice' again though 'subject always to the patient's clinical needs and best interests'. Members thus have, subject to the 'patient's best interests'

caveat, an obligation to use the relevant centre operated by the JV, in which they have an equity stake, but not to refer patients on to facilities operated by HCA.

- 8.61 HCA pointed out that these JV agreements in some cases incorporated non-compete obligations. For example, that governing the CyberKnife treatment facility prevents a consultant member of the JV holding an ownership interest in another business engaged in radiosurgery or other services provided at the CyberKnife centre. HCA pointed out that this clause did not limit the right of the consultant to practise at another private or NHS facility. It told us that, in the light of the substantial investments made and market risks faced by HCA, it considered these non-compete obligations to be entirely reasonable, proportionate and necessary. We note that 'non-compete' terms are contained in the LOC LLP agreement whereby member consultants are precluded from offering outpatient (though not inpatient or day-case) services at rival facilities within a 10-mile radius.

## *Nuffield*

### *GPs*

- 8.62 Nuffield told us that it had not in the last six years and did not currently have any arrangements in place with individual GPs, GP practices or other primary care organizations to prioritize referrals into its facilities and nor did it have any plans to do so in the future.
- 8.63 Nuffield provided us with details of premises that it owned where GPs currently practised and the terms on which these were provided. It told us that GPs practised at its Bournemouth, Brentford, Bristol, Derby, Guildford, Haywards Heath, Leeds, Oxford and Woking hospitals. It said that arrangements varied but that the most common was that facilities were not provided free and the hospital took a share of the fees generated by the GPs concerned.

### *Consultants*

- 8.64 Nuffield told us that in 2009 it introduced a national reward programme for consultants called Practice Privileges Plus (PP<sup>+</sup>). It said that the paramount aim of the scheme was patient care, that consultants were not precluded from working elsewhere and that the scheme was intended to be funded from economies of scale arising from increased business growth. Payments under the scheme were calculated on the amount of revenue that the consultant had generated and revenue growth in the current year. Thus the more revenue a consultant had generated previously, the more they could earn from the scheme, and the greater the growth on the prior year, the bigger the payout, up to a maximum of 3.5 per cent of the gross value of the consultant's earnings for the hospital the year previously. The grid for payments is reproduced in Figure 8.2.

FIGURE 8.2

**Nuffield's PP<sup>+</sup> scheme payout grid**

		Activity Growth Categories					
Loyalty Categories		£0 - £49k	£50k - £99k	£100k - £149k	£150k - £199k	£200k - £249k	> £250k
	£0k - £249k	0.00%	0.35%	0.70%	1.05%	1.40%	1.75%
	£250k - £499k	0.35%	0.70%	1.05%	1.40%	1.75%	2.10%
	£500k - £749k	0.70%	1.05%	1.40%	1.75%	2.10%	2.45%
	£750k - £999k	1.05%	1.40%	1.75%	2.10%	2.45%	2.80%
	£1,000k - £1,249k	1.40%	1.75%	2.10%	2.45%	2.80%	3.15%
	£1,250k - £1,299k	1.75%	2.10%	2.45%	2.80%	3.15%	3.50%
	£1,300k - £1,349k	2.10%	2.45%	2.80%	3.15%	3.50%	
	£1,350k - £1,399k	2.45%	2.80%	3.15%	3.50%		
	£1,400k - £1,499k	2.80%	3.15%	3.50%			
	£1,450k - £1,499k	3.15%	3.50%				
	> £1,500k	3.50%					

Source: Nuffield.

- 8.65 In 2012, Nuffield decided to close the scheme. It told us that the scheme had been designed so that additional incentives would not be required. However, hospitals were continuing to provide, for example, free consulting rooms, free telephone use, secretarial services on top of the benefits of the PP<sup>+</sup>. It said that these practices varied by hospital so were not easy to quantify and also risked negating the model rewards, as those who did not earn a financial reward could receive benefits in other ways. It said that, in addition, doctor groups were being formed and in some cases engaging with management companies to negotiate on their behalf, and therefore individual deals were being struck outside the PP<sup>+</sup> contract.
- 8.66 The document setting out Nuffield's analysis of the scheme indicated that the current regulatory intervention may have contributed to the decision to review and cease the PP<sup>+</sup> scheme. The report concluded:

However, the current climate emanating from the OFT investigation indicates that continuation of the PP<sup>+</sup> programme is not sustainable. Nuffield Health has stated publicly that 'We would like a ban to be considered on any form of financial incentive to consultants and GPs from private healthcare organisations. We believe this will help improve the service consumers receive by providing greater choice and easier access to the right healthcare professionals to suit their needs.' Nuffield Health has established a position on such incentives. A decision to delay the removal of PP<sup>+</sup> would be counter to this positive stance and create the appearance that any decision to remove PP<sup>+</sup> in the future was reactive to any future announcement by the OFT or the Competition Commission (CC).

The recommendation is that PP<sup>+</sup> contract termination is served soon as possible to meet the likely announcements regarding such incentive packages by the OFT or CC and in line with David Mobb's [group CEO] statement to the Times on 24<sup>th</sup> February 2012; with the effect of our maintaining our ethical stance on the subject and raising the spotlight on competitor practices.

## *Ramsay*

### *GPs*

- 8.67 Ramsay told us that it did not agree with offering direct financial incentives to GPs or other providers of primary care and did not make such incentives available. However, it regarded the role of GPs as sources of patient referrals as very important and that strong relationships with GPs were critical to its business success. It said that each of its hospitals employed a GP Liaison Officer who would regularly visit GP practices, inform practitioners about developments at Ramsay hospitals, introduce GPs to Ramsay consultants, discuss any issues with previous referrals and get feedback from GPs. It said that the only payments that it made to GPs were in return for services provided in attendance at its neurological rehabilitation units.
- 8.68 Ramsay told us that private GPs operated out of some of its hospital facilities. At its Springfield Hospital, for example, a group of private GPs rented two consulting rooms, an office plus reception and waiting area. The hospital charged the GPs £[redacted] per month for the use of these facilities which included the cost of employing two reception staff. Ramsay said that save for a free room provided at its West Midlands Hospital to support the NHS Abdominal Aortic Aneurysm screening programme, it did not provide any free or subsidized accommodation or services to GPs.
- 8.69 Ramsay told us that it strongly believed in the importance of GP education and training and that its hospitals regularly hosted 'lunch and learn' events at GP practices at which a consultant with relevant expertise would present on a topic of interest to GPs. In addition to these events, Ramsay told us that it organized educational seminars and workshops for GPs and practice employees and provided literature and reports, including information on the quality of the services at each of its hospitals.

### *Consultants*

- 8.70 Ramsay told us that it had operated just two financial incentive schemes in the previous three years and that these were offered at its Berkshire Independent Hospital. It said that both had now been terminated.
- 8.71 Ramsay told us that between January 2009 and June 2011 it operated a consultant revenue share scheme under which consultants received a payment equivalent to [redacted] per cent of the outpatient revenues they had generated for the hospital and [redacted] per cent of the inpatient revenues they had generated for the hospital in each quarter. At the same time as it introduced this scheme it also ceased subsidizing medical secretarial services which, from then on, had to be paid for on a full recovery basis. Ramsay told us that the scheme had been introduced by the then Regional Director without approval from Ramsay's executive team, that it was not a contractual scheme and that a total of £[redacted] had been paid out to consultants under it.
- 8.72 Ramsay said that urology consultants, operating as Reading Urology Partnership, had a separate but similar scheme which operated from January 2008 to June 2011 (when the partnership moved its practice elsewhere). Under the scheme, which was non-contractual and initial discussions over which had taken place prior to Ramsay's acquisition of Capio in November 2007, the partnership received a total of £[redacted] in payouts.
- 8.73 Ramsay told us that there were various 'support/benefit' arrangements in place at its hospitals, for example room rental and secretarial services, but that it was for each hospital to determine the appropriate charge for these. It said that in the majority of Ramsay hospitals consultants paid the standard (non-discounted) room rental fee but

that some of its hospitals discounted room rental or provided the consulting room free of charge for consultants who generated a high level of revenue for the hospital.

### ***Schemes adopted by other private hospital operators***

- 8.74 We examined the schemes adopted by some smaller private hospital operators as part of our research into episodes of market entry or expansion in Bath, central London and Edinburgh (see Appendices 6.1 to 6.3).

#### ***Circle***

- 8.75 As we set out in our case study on Bath (see Appendix 6.1), Circle differs from some of its competitors in that it offers consultants who commit to undertake a given proportion of their work at a Circle hospital an equity stake in the business.
- 8.76 Circle Health Limited, the parent company of the Circle operating group, is 50.1 per cent owned by Circle Holdings plc and 49.9 per cent owned by Circle Partnership Limited. Circle Holdings is the entity through which capital is raised to fund the growth of Circle's activities and Circle Partnership is the entity through which clinicians and employees are granted share ownership in Circle.
- 8.77 Circle subsequently told us that it was undergoing a significant corporate restructuring which, when completed, would result in Circle Health Limited becoming a 100 per cent subsidiary of Circle Holdings plc. Clinicians and employees who had previously owned shares in Circle Partnership would instead be granted mandatorily convertible shares in Circle Holdings plc, and future incentives would take the form of options granted over ordinary shares in Circle Holdings plc.

#### ***GPs***

- 8.78 Circle told us that in 2006/07 it had attempted to attract GPs to the partnership with a view to developing an integrated care model as practised in the USA. It said that the attempt was abandoned once it was clear that it was not appropriate for GPs to have a substantial role in Circle's partnership as this would pose inherent provider–commissioner conflicts. It said that a relatively small number of GPs remained as Circle shareholders but were not active within the Circle partnership.

#### ***Consultants***

- 8.79 Circle told us that when it identified a particular market that it believed was viable, it met with consultants in the area. In exchange for building a new hospital in the area, consultants were asked to commit a certain proportion of their private work, usually around 50 to 60 per cent, to the hospital but could terminate this contract with 12 months' notice after the first anniversary of the hospital's opening.<sup>700</sup> Upon entering into this agreement, the consultant typically received a small grant of Circle Partnership shares. Shares were offered to consultants at 'fair market value' determined annually by an independent valuer, though participants did not need to pay for them at the time of acceptance but only when they came to sell the shares. Circle

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<sup>700</sup> Circle later told us that it had last entered into a commitment letter with consultants in 2012, and that the commitment letters it had signed with consultants were themselves time limited. Consequently, all of the 115 consultants currently engaged at its two private facilities were able to terminate their commitments at any time. Further, it said that virtually all non-engaged consultants (ie consultants who had signed up to work at possible future Circle facilities) were no longer required to undertake any work at a future Circle facility.

said that any competitive concern that may have existed at the historic link between the initial small allocation of shares to a consultant and that consultant's revenue commitment no longer existed as consultants were no longer bound by their commitments.

- 8.80 Circle also told us<sup>701</sup> that, as a consultant's equity was 'pooled' with those of other scheme members, from nurses to porters to managers, they all realized value in their shares based on the group's overall performance. As a result, a consultant's individual referral behaviour would have no direct impact on the value of his shares and so his equity could not be said to influence his referral behaviour (or at least not to any degree that would contribute to an AEC).

### *Bupa Cromwell Hospital*

#### *GPs*

- 8.81 We included BCH in our case study of TLC's expansion of its cancer treatment facilities in central London.
- 8.82 BCH told us that its hospital site encompassed mews buildings, some of which were rented out to consultants and GPs. It said that there were [X] private GP practices operating out of the mews with lease agreements. It said that the rental for this accommodation had previously been dependent on the value of referrals made to BCH under agreements reached prior to Bupa's ownership of BCH. BCH confirmed that it had removed the direct link in these arrangements between the office rental value and referral fees, although rents were still subsidized with the extent of the subsidy depending on anticipated future revenue generation.

#### *Consultants*

- 8.83 BCH told us that it had operated schemes which provided consultants with direct financial incentives to refer patients to the hospital. These included a volume-related financial incentive scheme to encourage consultants to refer patients for [X] and [X], which has now ceased, where consultants received payment for referrals.
- 8.84 BCH told us that, as with GPs, it had been the practice at the hospital to subsidize rates at which consultants were provided with consulting rooms. Figures supplied to us indicate that these subsidies were valued at just over £[X] a year.
- 8.85 BCH said that since acquiring the hospital it had sought to rationalize and standardize its approach to consultant reimbursement but that, currently, using incentives was unavoidable to remain competitive in London if other hospitals were permitted to use them. However, it also expressed concerns regarding an 'arms race' developing between hospitals which, it said, would lead to the hospitals with the deepest pockets entrenching the relationships with consultants. It said that it had itself experienced the challenges of entering new services because it could not match the incentives offered by other large hospital operators in London.

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<sup>701</sup> [Response to provisional decision on remedies](#), February 2014, p9.

## *The London Clinic*

### *GPs*

- 8.86 TLC told us<sup>702</sup> that it was against hospitals providing any incentives to GPs.

### *Consultants*

- 8.87 In our case study on TLC's Cancer Centre, we reported an episode in which two consultants, [redacted]<sup>703</sup> at TLC, were contemplating transferring their practice to another hospital, believed by TLC management to be HCA's Platinum Centre at the Wellington Hospital. The Board of Trustees gave its 'exceptional'<sup>704</sup> permission to the management to come to an arrangement with the two consultants that would retain them.

- 8.88 The terms agreed included that the consultants concerned were under the following obligation to:

use best endeavours to procure that all referrals and diagnosis requiring other treatments are carried out at the Hospital and not at any other institution including, without limitation, the London Oncology Centre (LOC) and HCA hospitals. This requirement will not apply if it is concluded by the Contractor or the Consultant that, for clinical reasons, it is in the best interests of the relevant patient for treatment to take place elsewhere.

- 8.89 We also reported in the case study that TLC had an agreement with the LOC which it had signed in 2005 which obliged the LOC, in exchange for a £[redacted] loan from TLC, to refer patients to TLC. These obligations were quite extensive. LOC members were obliged to refer to TLC, and to use their best endeavours to cause all consultants working at the LOC to refer to TLC all new patients requiring inpatient admission and all outpatient and day-case patients who could not be treated at the LOC. Similar obligations applied to the referral of patients for general radiology, ultrasound and CT/MRI and, when TLC was able to provide these services, PET scanning, all radiotherapy and nuclear medicine imaging. In addition, the LOC was entitled to a £70 fee for each MRI scan undertaken by TLC arising from LOC referrals. These obligations were, however, subject to the 'patients' best clinical interests' caveat and subject to the GMC rules on *Good Medical Practice*.

## *Aspen*

- 8.90 Aspen became the owner and operator of the Edinburgh Clinic in 2011. The entry of the Edinburgh Clinic under its previous ownership into the Edinburgh market was the subject of our Edinburgh case study.

### *Consultants*

- 8.91 Aspen made a submission to us on the relationship between hospital operators and consultants, and specifically equity-based JVs. It said that, as it was US owned and by way of its close operational ties with United Surgical Partners International, it con-

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<sup>702</sup> TLC said that it was against hospitals providing any incentives to GPs: [TLC response hearing](#), paragraph 10.

<sup>703</sup> In excess of £[redacted].

<sup>704</sup> TLC told us that it was a 'one-off, defensive' arrangement.

formed to a number of US federal regulations intended to govern the illegal remuneration of physicians in the USA that was also translatable to consultants within the UK. It told us that there were a number of safe harbour provisions in the US Anti-Kickback statute which it sought to comply with in the UK. It said that the US regulations were more prescriptive than any current regulation within the UK and that by taking this stance it would avoid any ethical issues in relation to long-term equity investment models.

- 8.92 Aspen told us that it had a small number of equity-based JVs but that its strategy was not based entirely around consultant partnerships. It said that in most cases these took the form of an LLP which leased an Aspen-owned hospital and operated it. Consultants would then invest cash in return for an equity interest in the LLP. However, it said that it also had facilities which were originally owned by a group of consultants which Aspen had bought into by acquiring shares. It said that in all these arrangements it maintained managerial, operational and clinical control by owning more than 50 per cent of any interests or shares in the JV entity.
- 8.93 Aspen told us that the invitation to participate in a JV was extended to consultants already practising at an Aspen facility, rather than to attract new consultants to practise there, and that its agreements were based on five key principles:
- Consultants invest their own cash for a minority equity interest alongside Aspen and the price per equity unit is based on fair market value. No consultant was ever 'awarded' equity or received equity at less than market value in consideration of a commitment to make referrals.
  - Financial returns to consultants are derived from the profits of the JV and the return to each consultant is based on and proportionate to the level of the consultant's equity investment and not on the number of patients that the consultant treats at or refers to the facility.
  - The JV agreement requires the consultant to exercise clinical judgement when deciding on treatments or venues for patients and always to act in the patient's best interests.
  - The arrangement is transparent to patients, the JV agreement requiring the consultant to inform their patient of their stakeholding.
  - JV member consultants have the ability to sell their equity stake at any time.

### *Kent Institute of Medicine and Surgery Hospital*

- 8.94 The Kent Institute of Medicine and Surgery (KIMS), due to be completed in Maidstone in early 2014, will be an independent tertiary private hospital. KIMS told us that, as it would be the only tertiary hospital in the area (NHS or private), it would be able to provide treatment for patients who would otherwise have had to travel to central London for these tertiary procedures.

### *Consultants*

- 8.95 It said that 380 consultants had signed, or were in the process of signing, practising privileges agreements (PPAs) with it pursuant to which they had agreed to transfer some or all of their existing private patient practices to KIMS. KIMS said that, in many cases, patients would be treated by the same consultants that they would have seen



in the central London hospitals and that KIMS would be providing local competition to the London private tertiary hospital market currently dominated by HCA.

- 8.96 In the PPAs, KIMS agreed to pay consultants 5 per cent of the revenues received by the hospital for each pathology service, imaging service or surgical procedure ordered or performed by the consultant at KIMS. However, KIMS told us that the PPAs (including the clause providing for these payments) were currently under review. It said that the intention was to update the PPAs such that, instead of paying 5 per cent of gross revenues from each service or procedure in cash to the relevant consultant, 5 per cent of net revenues would instead be paid into a specially established trust with independent trustees. Any healthcare worker who worked within KIMS (whether employed or with practising privileges) could apply to the independent trustees for a grant, which could be used for research, development and/or teaching. Allocation of funds would be based on the merit of the proposal and would require submission to an independent research and development committee, having received ethics committee approval. KIMS was concerned that the CC's proposed prohibition on consultant incentives would affect this scheme, which was intended to improve the skills of consultants and ultimately benefit their patients and medicine generally.
- 8.97 KIMS said that, in order to raise financing for the new hospital, it had had to prove to its funders that a large number of consultants supported the new hospital and were willing to transfer their private practices to it. The funders insisted on consultants providing £5 million worth of personal guarantees of the bank debt and a cash equity investment of £1 million. In return, the approximately 70 consultants who provided guarantees were offered (in total) 5 per cent of the equity in the PropCo (which owns the land and buildings) and the OpCo (which will lease the hospital and operate it), and the 80 cash equity investors were offered (in total) 3 per cent of the equity in PropCo and OpCo. It said that every consultant who signed a PPA and started work at KIMS would share in 2 per cent of the equity in the PropCo and OpCo. KIMS said that, without this equity ownership, the project would in all likelihood never have happened.

### *Nueterra*

- 8.98 Nueterra Healthcare International (Nueterra) is an operator of hospitals and other healthcare facilities in the USA and told us that it had been developing plans to enter the UK and European private healthcare markets.

### *Consultants*

- 8.99 Nueterra said that its business model relied on the active participation of consultants in the ownership and management of its healthcare facilities. Its intended model in the UK would see Nueterra owning the majority stake in any facility, with consultants eligible to own up to 49 per cent (typically consultants would have small individual shareholdings of 1 to 3 per cent). These shares would be paid for in cash by the consultants, at fair market value, and there would be no commitment to refer patients to Nueterra facilities. When profits were available they would be distributed pro rata to shareholdings, and not in accordance with referrals or revenue generated by individual consultants. Consultants would be expected to make referrals based on what was in the best interests of their patients. Nueterra said that it would expect a consultant to refer all potential suitable patients to the facility in which they had invested, but there was no obligation on them to do so, nor any direct financial reward by reference to the number of referrals. The only requirement was that the consultant would be obliged to sell their shares if they stopped practising in the facility. The existence of

the consultant's financial interest in the facility would be disclosed and transparent to patients (as is the case, by law, in the USA).

- 8.100 Nueterra told us that, in its view, its model made for good and innovative management, improved quality and efficiency, and led to better outcomes for patients and their PMIs in terms of price. It said that it believed its model was pro-competitive as it created cost efficiencies and promoted a higher quality of service and facility. If it was not able to secure the active participation of consultants as a result of CC action, then Nueterra would be much less likely to invest in the UK.

## ***Views of the parties***

### ***Hospital operators' views***

- 8.101 Private hospital operators, in their submissions on this issue, generally argued that in some parts of the country the practice of offering incentives to consultants had become commonplace since it was necessary to do so in order to attract key consultants and that competition for consultants was intense.<sup>705</sup> Some said that they would welcome clarification from us on the merits and demerits of various types of scheme.
- 8.102 We have cited above hospital operators' comments provided to us in response to our questions about their schemes. Some of the hospital operators also provided views and comment in response to our annotated issues statement and our provisional findings. Our annotated issues statement raised the question as to whether incentive schemes gave rise to barriers to entry and some of the responses received (most notably that from HCA) focused on that issue. In our provisional findings, we found that schemes to attract business by encouraging clinicians to refer patients to or treat patients at private hospital operators' facilities were widespread, albeit they were much more commonly directed at consultants than at GPs. We provisionally concluded that the existence of incentive schemes operated by private hospital operators which encouraged patient referrals for treatment at their facilities, whether in cash or kind and whether related to the value of referrals or not, were a feature of the market that gave rise to an AEC. We also provisionally concluded that equity ownership by consultants of private health facilities was a feature that gave rise to harmful effects on competition, except where such ownership resulted in a reduction in barriers to entry that was likely to be at least as beneficial to competition as any distortion was harmful. A number of responses received focused on the benefits of equity ownership and the distortions that could arise if equity ownership was permitted for new entrants but not for other operators.

### ***BMI***

- 8.103 In response to the annotated issues statement, BMI made limited additional comments. It noted the importance of competition for consultants and said that this competition drove hospitals to meet the existing and future needs of patients as effectively and efficiently as possible. It said that it welcomed the role of the CC with respect to defining the boundaries of useful and pro-competitive interaction between consultants and PHPs. It made no further comments in response to the provisional findings. In responding to the Remedies Notice,<sup>706</sup> BMI said it did not consider that there was a compelling competition case to prohibit incentive schemes [§] those of its schemes which fell within the CC's 'direct incentives' category. It said that, from a

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<sup>705</sup> See, for example, [General Healthcare Group's response to the issues statement](#), paragraph 2.3b.

<sup>706</sup> [BMI response to Remedies Notice](#), paragraphs 32.1 & 32.2.

competition perspective, the conclusion that clinician incentives gave rise to an AEC was unfounded and wrong but that BMI was content to see a remedy implemented, as it believed patients would be better served without such schemes.

#### HCA

- 8.104 HCA said that the CC had not presented any evidence that hospital/consultant agreements were creating foreclosure effects in local healthcare markets, or specifically any evidence of foreclosure in London,<sup>707</sup> and that, overall, the evidence discussed in Appendix E of the annotated issues statement did not bear out the concerns that these agreements constituted barriers to entry or expansion.<sup>708</sup> HCA also said that, in the light of the CC's and OFT's consultant survey evidence, which HCA said revealed the relatively low number of consultants that were aware of or had been offered incentives/benefits by private hospitals,<sup>709</sup> it was difficult to see how incentive arrangements could create material barriers to entry where they involved such a relatively small group of consultants. With respect to London, HCA said that there was a relatively large pool of NHS consultants (over 7,500) which ensured that new entrants had ready access to consultants who needed to undertake a private practice. In these circumstances, it was inconceivable that any of the types of schemes described in Appendix E were likely to have material foreclosure effects in the London market.<sup>710</sup>
- 8.105 HCA noted that new entrants were able to compete to attract consultants on exactly the same terms and conditions as incumbent hospital operators. It said that the incumbent enjoyed no inherent advantages and that there was no reason why new entrants were not able to offer the same incentives in order to attract consultants to a facility.<sup>711</sup> In that regard, HCA pointed to Circle's consultant incentive model which HCA said had allowed Circle to attract consultants in a relatively short space of time, and thereby attract significant volumes of business, which had served as Circle's route to market.<sup>712</sup> HCA submitted that hospital/consultant collaborative agreements provided a means for providers to establish new facilities or expand existing ones by attracting consultants, creating new, innovative types of ventures and motivating consultants to develop new services.<sup>713</sup> HCA drew our attention to recent GMC guidance that it said acknowledged that consultants may have financial or commercial interests in healthcare facilities provided they did not allow conflicts of interest to arise and disclosed these interests to their patients.<sup>714</sup>
- 8.106 HCA also wrote to us commenting on AXA PPP's response to the annotated issues statement. HCA strongly disagreed with AXA PPP's claim that HCA incentivized consultants to use new technologies rather than better value-for-money alternatives. HCA told us that it placed paramount importance on good clinical practice and had instituted clinical governance measures to achieve this, providing examples of these measures. HCA argued that AXA PPP, rather than the consultants, had a fundamental conflict of interest in relation to new technology. HCA said that AXA PPP's approach to innovation and new technology was determined primarily by cost con-

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<sup>707</sup> [HCA response to annotated issues statement](#), paragraph 7.32.

<sup>708</sup> *ibid.*

<sup>709</sup> *ibid.*, paragraph 7.33.

<sup>710</sup> *ibid.*, paragraph 7.40.

<sup>711</sup> [HCA response to issues statement](#), paragraph 13.24. HCA made reference to the European Commission's guidelines on abuse of exclusionary conduct: 'If competitors can compete on equal terms for each individual customer's entire demand, exclusive purchasing obligations are generally unlikely to hamper effective competition unless the switching of supplier by customers is rendered difficult due to the duration of the exclusive purchasing obligation.'

<sup>712</sup> [HCA response to annotated issues statement](#), paragraph 7.39.

<sup>713</sup> [HCA response to issues statement](#), paragraph 13.14.

<sup>714</sup> [HCA response to annotated issues statement](#), paragraph 7.41.

siderations and therefore it had little incentive to promote and encourage hospital providers to innovate and improve patient outcomes where those innovations may not lead directly to cost savings for AXA PPP in the short run.

- 8.107 HCA also said<sup>715</sup> it agreed that there may be a case for prohibiting schemes which provided benefits directly linked to patient referrals. However, it thought that we should consider equity partnership schemes, and the pro-competitive effects arising from them, in detail. These pro-competitive effects could arise through a closer partnership between a consultant or group of consultants and a private healthcare provider. It said that certain innovative treatments or the development of specific units might only be brought about through a firm commitment of effort and resources over a certain time period from both a consultant or group of consultants and a private healthcare provider. Equity partnerships facilitated innovation by existing market players (as well as facilitating new entry) and so were pro-competitive. It said that the distinctions drawn by the CC in our provisional findings between incentive schemes that related to an entire medical facility and those that related only to clinical equipment or technologies was inappropriate.
- 8.108 HCA said<sup>716</sup> that the scale of payments typically made to consultants under equity schemes was unlikely to create a significant incentive effect. The median consultant equity investment in its JVs was around £[§] and the annual payment to the consultant was £[§], which it said was not enough to create an incentive to carry out unnecessary tests.

#### *Nuffield*

- 8.109 Nuffield<sup>717</sup> described consultant incentive schemes as a 'key barrier to entry'. It said that it believed hospitals should compete for consultants on the quality of service they provided to patients, not the quantum of (direct or indirect) incentives offered to their doctors. It said<sup>718</sup> that there should be a complete ban on consultant incentive schemes, whether financial or otherwise.

#### *Ramsay*

- 8.110 Ramsay said<sup>719</sup> that it did not then have any such incentive schemes with either consultants or GPs. It also said:

Ramsay considers that the issue of incentive schemes goes beyond barriers to entry and that such schemes raise serious ethical issues. It is Ramsay's view that consultants and GPs must be free to provide patients with the most appropriate treatment and that clinical judgment should be inviolable. Financial incentives to refer patients to certain hospitals potentially interfere with that clinical judgment and therefore are unethical. Other jurisdictions have recognized that such incentive schemes raise ethical issues and accordingly they are not permitted (see, for example, the USA and Australia).

- 8.111 Ramsay told us<sup>720</sup> that incentive arrangements which were directed at improving the quality of service and care received by patients did not give rise to an AEC, whereas

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<sup>715</sup> [HCA response to provisional findings](#), section 8.

<sup>716</sup> [HCA response to the Remedies Notice](#), paragraph 9.17.

<sup>717</sup> [Nuffield response to annotated issues statement](#).

<sup>718</sup> [Nuffield response to provisional findings](#), paragraph 4.2.

<sup>719</sup> [Ramsay response to annotated issues statement](#).

<sup>720</sup> [Ramsay response to Remedies Notice](#).

those which had the objective of seeking to reward consultants, directly or indirectly, for sending patients to a particular facility, did. It said that the latter type of incentive could interfere with clinical decision-making to the detriment of patients, whether the incentive was received in the short, medium or long term. Ramsay told us that it had led the way in the UK in ending direct payments to consultants for referrals. This reflected Ramsay's practice in Australia and the manner in which it had exported 'best in class' principles to the UK. As such, Ramsay said that it did not make financial payments to consultants to reward referrals and consultants were not offered equity interests. It said that it did not 'lock in' consultants to its hospitals.

### *Spire*

- 8.112 Spire said<sup>721</sup> that it did not believe that it was appropriate for hospital operators or insurers to offer GPs incentives in return for referring patients to a particular private hospital operator or alternative healthcare provider.
- 8.113 Spire suggested that problems that may be caused by incentive schemes could be addressed by a bar on arrangements that could risk distorting consultant referral patterns, such as volume and revenue incentives, and full disclosure of all other consultant arrangements.
- 8.114 Spire also said that if the CC were minded to restrict, or even prohibit, consultant arrangements, Spire would not have any commercial difficulty competing in such an environment.<sup>722</sup>
- 8.115 Spire did, however, warn that an outright ban on consultant incentives might have unintended consequences, of which it gave two examples. First, it could raise the costs of consultants entering private practice to a prohibitive level. Second, it could result in a ban on co-investment by consultants in facilities and services, and as a result certain new services might not be introduced to the market.<sup>723</sup> It reiterated these views in its response to our provisional findings (see paragraph 8.118).
- 8.116 Spire was concerned that PMIs appeared to have raised concerns with the CC that implied that overtreatment or overdiagnosis might be occurring. It said that:
- Spire has clinical governance systems in place to protect against both over- and under-treatment. In a case where Spire found evidence of either over- or under-treatment by a consultant at one of its hospitals, it would not hesitate to refer that consultant to the GMC. It appears that the PMIs have raised over-treatment as a concern with the CC. Spire engages in regular discussions with all of the major PMIs in the UK on a wide variety of topics relating to its business and the PMIs have not raised over-treatment as a concern. If over-treatment were an issue in Spire hospitals, Spire would expect the PMIs to raise it during these discussions. No PMI has done so during the period in which Spire has owned the hospitals.<sup>724</sup>
- 8.117 Spire also said that the level of treatment available in the NHS may not be an appropriate point of comparison for the level of treatment available in private facilities in light of significant objective evidence of under-treatment in the UK. It said that the fact that certain diagnostic tests and treatments may be more widely available and

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<sup>721</sup> [Spire response to annotated issues statement](#).

<sup>722</sup> [Spire response to annotated issues statement](#), paragraph 6.4.

<sup>723</sup> [Spire response to annotated issues statement](#), paragraph 6.4.

<sup>724</sup> [ibid](#), paragraph 7.4.

more frequently provided in private facilities than in the NHS did not therefore reflect overprovision in the private sector.<sup>725</sup>

- 8.118 In its response to our provisional findings,<sup>726</sup> Spire said that while it agreed with most of our views on clinician incentives, it was concerned that we had overstated our analysis and risked including within the AEC many arrangements that benefited patients by bringing new services to the market. It said that we had failed to identify that offering free or discounted consulting rooms and administrative support to consultants entering private practice for the first time, for a limited period, facilitated entry into the market by new consultants. Spire said that we had assumed that hospital operators would invest in such arrangements only if they believed them to be effective in attracting business, but we had not adduced any evidence that these precise practices had an AEC. It also said that we had not provided any evidence, reasoning or analysis to support the assertion that all schemes relating to a single item of equipment or another service below the level of a full-scale hospital were problematic. It said that such schemes could frequently result in the delivery of a new service, treatment, or even a new competitor to the marketplace which would not happen absent the scheme.

### *PMIs' views*

- 8.119 The PMIs generally strongly criticized incentive schemes for consultants, expressing concerns about both medical and competitive effects. Bupa and AXA PPP both made extensive submissions on the subject.

### *Bupa*

- 8.120 In its response to our issues statement, Bupa included an annex<sup>727</sup> that discussed 'unwarranted variation' in healthcare, referring to variation 'that cannot be explained by clinical needs, patient preference or the capacity of the health system'. It argued that unwarranted variation was driven by conflicts of interest facing the clinician, the fee-for-service reimbursement model, information asymmetries, a lack of effective competition between clinicians, and a lack of credible oversight and sanction.
- 8.121 Bupa provided five case studies relating to different types of treatment.<sup>728</sup> Two of the case studies indicated that Bupa's patients were much more likely to receive certain treatments<sup>729</sup> for these conditions than patients of the English NHS. Bupa noted that the NHS (England) was not a perfect benchmark, but said that the extent of private treatment, which was in some instances three or four times greater than in the NHS (England), raised significant concerns as to whether all interventions were required. Two case studies<sup>730</sup> indicated that there was significant variation between clinicians within private practice into the way treatments were delivered, for example some private clinicians continued to use treatment practices that were out of line with evidence-based medical guidelines. The fifth case study indicated that patients who were referred by their GP to a cardiology consultant who did not have appropriate skills to serve their specific condition faced a significantly greater number of tests, costs and delay before receiving the required treatment.

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<sup>725</sup> *ibid*, paragraphs 7.5–7.6.

<sup>726</sup> [Spire response to provisional findings](#), paragraph 7.3 et seq.

<sup>727</sup> [BUPA response to issues statement](#), Annex E.

<sup>728</sup> Four of these were in the [BUPA response to the issues statement](#), Annex E. A fifth was provided in a response to our market questionnaire.

<sup>729</sup> Knee Arthroscopy and Shoulder Repair.

<sup>730</sup> Wisdom Teeth and Hysterectomy.



- 8.122 Bupa also described medical review processes that it launched for two procedures in 2011. These medical reviews required the consultant to explain in a short form why the proposed treatment was necessary and in line with best practice medical guidelines before funding was authorized. Bupa told us that it had observed an immediate, significant and sustained reduction in the number of procedures ordered by consultants. Bupa said that this indicated that some consultants did not believe they had sufficient medical grounds to justify the procedure.
- 8.123 In response to our Remedies Notice, Bupa said that it agreed with the CC that incentive arrangements between private hospital operators and consultants give rise to an AEC. It said that it strongly agreed with the need to remove such arrangements (whether they were short term or long term), as the CC contemplated. It said that the most clear-cut and effective remedy would be to prohibit all incentive arrangements between consultants and private hospital operators. There were good precedents for this action internationally and this action would be consistent with GMC *Good Medical Practice* guidelines.<sup>731</sup> However, Bupa did not agree with our conclusion that cases of overtreatment as a result of economic incentives were likely to be few and far between.<sup>732</sup>

#### AXA PPP

- 8.124 AXA PPP considered that the practice represented an additional theory of harm. It argued that consultant incentives to refer patients and/or commissioning excessive treatment had a distortive effect. It said that while medical specialists endeavoured as part of their professional ethical obligations to act in the best interests of patients, consultants were far from immune to responding rationally (if often subconsciously) to financial incentives that in this case distorted competition by raising entry barriers and leading to cost inflation.<sup>733</sup>
- 8.125 AXA PPP provided several examples of instances which demonstrated, in AXA PPP's view, inappropriate and at times unethical practice. AXA PPP also drew our attention to a paper<sup>734</sup> from the USA. This, it said, showed a clear increase in the incidence of tests being ordered when they could claim fees for interpretation and again, when they also billed for the facility. For stress echocardiography, the increasing likelihood of tests being ordered was 7.1 times more likely if the doctor also charged fees for interpretation and 12.8 times more likely if the doctor charged fees for the use of the facility as well.<sup>735,736</sup>
- 8.126 AXA PPP<sup>737</sup> said that hospital operators should be prevented from offering to consultants any incentives in cash or kind, direct or indirect. It said that, similarly, consultants should be prevented from asking for, or accepting, any such incentives. In its view, all incentives of any kind, including equity ownership, should be banned.
- 8.127 In addition, AXA PPP said that it recognized that hospital groups may have bona fide grounds for wishing to seek advice from experienced medical practitioners, including those who have active and ongoing medical practices. There was in principle no objection to such individuals being employed on normal and reasonable terms. However, there is a concern that such arrangements could be used as a reward

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<sup>731</sup> [Response to Remedies Notice](#).

<sup>732</sup> [Response to provisional findings](#), paragraph 5.8.

<sup>733</sup> [AXA PPP response to annotated issues statement](#), paragraph 1.3.

<sup>734</sup> 'Association between Physician Billing and Cardiac Stress Testing Patterns following Coronary Revascularization', *JAMA*, 9 November 2011, Volume 306, No 18.

<sup>735</sup> [AXA PPP response to annotated issues statement](#), paragraph 3.5.

<sup>736</sup> HCA strongly disagreed with parts of AXA PPP's response to the annotated issues statement. See paragraph 8.106.

<sup>737</sup> [AXA PPP response to provisional findings](#), paragraph 1.23.

mechanism, for example by attaching an elevated remuneration to such positions, and by offering them to individuals who did generate, or who recently had generated, large volumes of business for the hospital group in question.<sup>738</sup>

### *The GMC*

- 8.128 The GMC told us that it had a legal power to give advice to the profession on standards of professional conduct and medical ethics but that its guidance (*Good Medical Practice*) did not have the force of a statutory code of practice. However, the GMC told us that it provided the framework for the GMC's fitness to practise procedures and that serious or persistent failure to follow its guidance would put a doctor's registration at risk.

### *Clinicians' representatives*

- 8.129 We received few comments from bodies representing doctors on the issue of incentives to clinicians offered by private hospital owners.
- 8.130 The BMA said that the CC should consider whether consultant incentives could serve to raise barriers to entry. It noted, however, that since indirect incentives such as free or discounted consulting rooms were widespread, they were unlikely to act as a barrier to entry. The BMA also said that GP referrals should be based on clinical decisions, not financial incentives, and that GP incentives raised ethical issues and would be contrary to GMC guidance.<sup>739</sup>
- 8.131 The AAGBI said that it opposed consultant incentives provided by private hospital operators, as described in the OFT's report, but drew our attention to the practice of private hospital operators paying surgeons higher hourly rates than anaesthetists when operating on NHS patients in private hospitals. It said that this represented a covert incentive to induce surgeons to bring privately-funded patients to private hospital facilities.<sup>740</sup>
- 8.132 FIPO said that it was, in principle, against all incentive schemes which led to foreclosure and that in a properly functioning competitive market, hospitals should compete to attract the services of consultants based on their facilities (eg state-of-the-art equipment, competent staff), and there ought to be a total ban on private hospital operators, as defined, to offer incentive schemes, except for bright line cases such as help for an initial period for newly appointed consultants.<sup>741</sup> FIPO said that it had no objection to equity partnerships between doctors and hospital operators provided that they were not linked to any specific anticompetitive agreement but that the overriding consideration in looking at incentive schemes was that they should be compliant with the GMC *Good Medical Practice* guidelines.<sup>742</sup>

### ***Assessment of clinician benefits and incentives***

- 8.133 We found that private hospital operators used a variety of methods to encourage clinicians to treat patients at or commission tests from their facilities. These included marketing communications and promotional events but also extended to the provision of benefits, services and financial incentives in the case of consultants. We

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<sup>738</sup> [Response to provisional decision on remedies](#), paragraph 71.

<sup>739</sup> [BMA initial submission](#) and [response to Remedies Notice](#).

<sup>740</sup> [AAGBI initial submission](#) and [response to provisional decision on remedies](#).

<sup>741</sup> [FIPO response to Remedies Notice](#).

<sup>742</sup> [FIPO initial submission](#).



found that schemes to incentivize GP referrals were rare but that discounted room rentals were provided to GPs.

- 8.134 Benefits provided included, at one end of the spectrum, low-value items such as free tea and coffee and newspapers, which might also be made available to members of the hospital staff as well as consultants. However, hospital operators also offered clinicians higher-value benefits such as free or subsidized consulting rooms and parking spaces, payment of or contributions towards medical indemnity insurance and free or subsidized secretarial services. In addition, we found formal incentive payment schemes which linked consultant performance in terms of revenue generation to cash rewards. We found that cash-based incentive schemes became much less common from around 2011, though equity participation arrangements, which shared some of the characteristics of these incentive schemes, became more common.
- 8.135 What was relatively common was the lack of transparency in relation to such schemes. The parties were very reluctant for the CC to disclose the existence, let alone the details, of their schemes whether with individual consultants at particular facilities or even more formal arrangements. Although we found such schemes to be widespread, our survey found very few consultants willing to admit that they were aware of them. We found very little evidence that patients or the insurers were informed by either the hospital operators or the consultants of the existence of such schemes. This includes more formal arrangements, such as Spire's arrangements with the Mosaic group and BMI's arrangements with the Syon clinic, among others.
- 8.136 We concluded that the value of certain benefits provided to consultants practising at their facilities by hospital operators, like free tea and coffee, were so low that they would be extremely unlikely to influence their conduct and therefore distort competition between hospital operators. We concluded that the extent to which the provision of other benefits and incentive schemes or privileges<sup>743</sup> to consultants would affect their conduct would depend upon:
- (a) the value to the consultant of that benefit's provision (or the cost and inconvenience of its withdrawal); and
  - (b) the extent to which its provision (or withdrawal) was linked to the consultant's own behaviour.
- 8.137 In the remainder of this section, we set out the reasoning underlying these conclusions, particularly as regards incentive schemes adopted by hospital operators whose object it is to encourage clinicians to make use of their facilities. However, it was put to us that certain professional services agreements between hospital operators and clinicians could give rise to similar obligations or incentives if the fee for such services was in excess of their market value.<sup>744</sup>
- 8.138 We received no evidence that professional services contracts were being used to influence clinician referrals in this way. We have therefore excluded them from our analysis here but consider the issue of these and other arrangements which could be used to circumvent our remedy and incentivize consultants to make referrals in the context of remedies.

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<sup>743</sup> For example, preferential access to prime theatre slots.

<sup>744</sup> AXA PPP response to provisional decision on remedies , paragraph 71.

### *Prevalence of incentive schemes*

- 8.139 We found that schemes operated by private hospitals to encourage clinicians to treat patients at or commission tests from their facilities were widespread.
- 8.140 We found that these were much more commonly directed at consultants than at GPs or other clinicians and found only one, a pilot scheme, where payments to GPs were directly linked to referrals. The provision of consulting rooms for GPs at was, however, relatively common and in some cases the availability of rooms was linked (implicitly or explicitly) to the volume of their referrals.
- 8.141 We found that incentive schemes were not confined to particular geographic areas or types of hospital operator: some independent private hospital operators as well as all of the main private hospital groups had, to a greater or lesser extent, adopted them.<sup>745</sup> However, there was some evidence that schemes which directly rewarded consultants for referrals were most likely to be adopted during periods, in geographic areas and in medical specialisms where competition for consultants was evident.<sup>746</sup>

### *Types of scheme*

- 8.142 The schemes varied in nature, value and sophistication and could provide benefits either in kind or in cash.
- 8.143 Incentive schemes differed in particular as to whether or not the size of the benefit to which the clinician was entitled varied in relation to the amount of business they brought to the hospital. Incentive schemes which entitled clinicians to benefits based on the volume or value of business they brought to the hospital, and which we refer to as 'direct' incentive schemes, became less common after 2012, coincident with the OFT's market study and the commencement of our market investigation.
- 8.144 We found that schemes introduced after this date were more likely to commit consultants to undertake an agreed proportion of their private work at the private facility concerned, or to work there for a minimum period. In exchange, consultants would be rewarded, or would have the prospect of a reward, based on the increase in the value of the hospital business over the period concerned. These schemes were usually part of or associated with equity participation or JV arrangements.

### *Incentive schemes and clinician conduct*

- 8.145 There are two main types of advice given to patients by doctors, namely which provider (ie consultant and private healthcare facility) to select and what diagnostic tests or treatments to undergo. We considered the extent to which incentive schemes might affect each of these and whether some schemes were more likely to do so than others.

#### *Choice of facility*

- 8.146 The competitive harm that potentially arises from clinician incentives is that they might, despite caveats relating to patients' best interests, incline consultants to recommend treatment at a particular private healthcare facility rather than another

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<sup>745</sup> As described above, Ramsay's adoption of such schemes in particular has been very limited.

<sup>746</sup> See paragraph 8.16 above in relation to BMI's Mount Alvernia and Bath schemes and Appendices 6.1 and 6.2 for the Bath and London case studies.

facility which may have equivalent or better facilities and/or which may be more competitive on price. Patients would not be aware that the clinician may have other incentives to recommend a particular facility or particular treatment or diagnostics.<sup>747</sup> In these circumstances, hospital operators may choose to compete over the value and nature of rewards that they offer to attract referrals rather than on the basis of the quality or price of their services. Indeed, several hospital operators confirmed that this was their reason for offering clinician benefits and incentives. We considered whether some benefits and incentive schemes were more likely to give rise to competitive concerns than others. We distinguished, as above, between direct and indirect benefits and incentive schemes.

- 8.147 Direct benefits and incentive schemes we define as those which explicitly or implicitly entitle clinicians to cash or other benefits in direct proportion to the volume or value of business that they themselves deliver to the private healthcare facility. At its crudest, a direct incentive scheme could comprise a fee per patient referred. More sophisticated schemes that we found included those which adopted a tiered (eg 'Bronze, Silver, Gold') approach to the award of benefits: they provided consultants with access to additional services or privileges, such as secretarial assistance, or preferential access to facilities, on the basis of the revenue that they, individually, brought to the hospital.
- 8.148 Indirect incentive schemes we define as those where rewards to a clinician are not linked to their individual performance, though they may be linked to the performance of a department or the facility overall. We reasoned that indirect incentive schemes were likely to have less effect on clinicians' behaviour than direct schemes because under indirect schemes the linkage between behaviour and reward is looser.
- 8.149 By extension, we reasoned that the incentive effect of a scheme would decrease as the strength of the linkage between an individual's behaviour and their reward became weaker. We considered that a fee-per-referral scheme, for example, would be the most likely to influence a clinician's behaviour, and indeed that is its purpose. We thought that a scheme where individual rewards were based on the performance of a group of participating clinicians would do so to a lesser extent and that the incentive effect, and thus the risk of market distortion, would decrease as the size of the pool of participants increased.
- 8.150 Schemes based on pools comprising groups of clinicians have similar characteristics to some of the equity participation schemes described earlier in that in both cases rewards based on collective performance are shared among a group of shareholders and the individual's interest in the reward pool and their capacity to influence the size of it is diluted.

### *Views of parties*

- 8.151 It was put to us by both hospital operators and PMIs that equity participation by clinicians had benefits for patients and hospital operators. Circle in particular said that there was a growing body of evidence that clinical leadership and engagement improved the quality of patient.<sup>748</sup> It said that when consultants were given not simply a 'say' in how care was delivered but meaningful operational and decision-making power, it ensured that the care patients received was determined by the individuals

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<sup>747</sup> Even if patients were aware, the asymmetry of information between the patient and the consultant as to which facility (or treatment or diagnostics) might be the most appropriate, and the trust that a patient typically places in his or her consultant, means that transparency alone would not be sufficient to remove the taint from a recommendation which has been influenced by incentives.

<sup>748</sup> See, for example, 'When Clinicians Lead', *McKinsey Quarterly*, February 2009.

best placed to make that determination. It also said that equity participation schemes should not be limited to allowing clinicians to purchase shares but should also permit hospital operators to grant clinicians options to purchase shares for a given price at a future date.<sup>749</sup>

- 8.152 Circle told us<sup>750</sup> that the purpose of its share scheme was to incentivize clinicians in their work, by asking them to think of themselves as co-owners of their Circle facility so that they would assume managerial, operational and business development responsibilities that improve the way Circle could deliver care to its patients and value to its customers (PMIs). It said that equity did not have the causal relationship over a consultant's referral behaviour as cash payments and free medical secretaries did. As a consultant's equity was pooled with that of other scheme members, from nurses to porters to managers, they all realized value in their shares based on the group's overall performance. Circle said that, as a result, a consultant's individual referral behaviour would have no direct impact on the value of their shares and so their equity could not be said to influence their referral behaviour, or at least not to any degree that would contribute to an AEC.
- 8.153 Circle said that not only was equity distinguishable from direct incentives, but several operators and some PMIs had recognized that it also served to attract and incentivize consultants in ways that benefited competition. Specifically, equity (a) enabled new entrants to attract financing for new facilities; and (b) created an ownership culture that encouraged better clinical engagement, which led to better clinical outcomes. It said that the resulting clinical engagement spurred innovation and investment across all sectors and specialities, which enhanced competition among providers to improve clinical services and the overall patient experience. The purpose of shares, in Circle's view, was to encourage broader clinician engagement through ownership rather than simply to reward consultants for treating patients.
- 8.154 Aviva submitted similar arguments. It said that it thought equity schemes could be positive because they engaged consultants in decision-making and gave them an interest in ensuring that the hospital delivered the appropriate quality of care to patients.
- 8.155 KIMS told us that it believed its equity partnership with consultants lowered the entry barriers and allowed consultants to develop patient care pathways and improve clinical outcomes in a way that they could influence and control, and was therefore beneficial to competition.
- 8.156 AXA PPP, on the other hand, saw no justification for equity incentive schemes,<sup>751</sup> and said that, while indirect incentives may be less stark than direct incentives in relative terms, in absolute terms they would still be likely to influence referral patterns and the only solution was to prohibit payments/transfers of value. It said that the suggestion that doctors were more interested in the quality of care because they had a financial interest was a worrying one. In its view, a doctor may be disinclined to whistleblow against malpractice or medical problems in a hospital if, as an investor in that hospital, they stood to lose significant wealth were the hospital to be fined or to lose customers. AXA PPP said that it had long held the view that, for example, the

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<sup>749</sup> Circle also said that it believed it should be allowed to grant options with an exercise price set at a discount to the market price of Circle shares at the date of grant in order to 'incentivize' consultants to work at its hospitals, and that whether or not options so granted would vest (ie become exercisable) would depend on a variety of criteria including participation in clinical leadership and operational management roles, service design, business development, EBITDA margin improvement, and volume of clinical work performed (with the latter factor accounting for approximately one-third of the overall assessment). It said that there would be no contractual requirement for consultants to bring all (or any) of their clinical work to a Circle facility.

<sup>750</sup> Circle response to provisional decision on remedies, p9.

<sup>751</sup> AXA PPP response to the provisional decision on remedies.

Circle model was contrary to the interests of private patients and viewed it as a model built upon financial incentivization. It also disputed Circle's claim that the article cited above (footnote 748) supported the idea that doctors' involvement in healthcare facilities led to improved quality. It said that the McKinsey article actually looked at the issue of doctors in management and leadership roles and quoted examples from NHS public services and integrated management care organizations such as Kaiser Permanente. These were very different environments from a fee-for-service model as practices in the private sector in the UK. Instead, it referred us to a more recent report by the US Centre for Healthcare Research and Transformation,<sup>752</sup> which said that a substantial body of research showed that ownership and self-referral were associated with increased utilization and higher system costs, low same-day referral, and diversion of unprofitable complex patients and Medicaid beneficiaries away from physician-owned facilities.

- 8.157 Spire<sup>753</sup> thought that equity participation could be an effective way of incentivizing consultants to commit to working at a new hospital and so could support entry by new facilities. It said that equity or partnership arrangements for diagnostics or other equipment could facilitate entry, even if on a smaller scale. Certain schemes could frequently result in the delivery of a new service, treatment, or even a new competitor to the marketplace which would not happen absent the scheme. It said that co-investment vehicles were necessary to support hospital investment and to develop new and enhance patient services. It thought this was all the more important in the face of aggressive PMI cost pressure motivated solely by cost savings at the expense of innovation and without any regard to patient welfare.

*Consultants' advice on diagnostic tests and treatment*

- 8.158 The second type of advice to patients we considered is in regard to diagnostic tests and subsequent treatment, where consultants are generally the most influential if not the sole source of advice. Customer detriment in the form of higher prices and lower-quality medical care could thus potentially arise from the commissioning of unnecessary tests or treatment.
- 8.159 PMIs told us that they believed that overtreatment and overdiagnosis occurred, though reliable evidence that they did so is difficult to find. Bupa cited analyses of variation in treatments between NHS and Bupa patients in aggregate in support of this view. However, we note that comparisons with the NHS in England may not be wholly reliable as the capitation-based remuneration structure of the NHS may encourage undertreatment or underdiagnosis.
- 8.160 Similarly, research from the USA suggests that financial incentives can lead to overtreatment but it is not clear that the US situation is fully comparable with the UK. Hospital operators strongly disputed that there was any relevant evidence of overtreatment or overdiagnosis and pointed to their governance arrangements as a check on such activity.
- 8.161 We concluded that the same considerations as regards type of incentive scheme would apply here as in choice of facility, and that tensions between a clinician's professional obligations and personal interest would be most likely to arise in circumstances where his or her own conduct could have a material effect on the reward received under the arrangement. We thought that this effect would be most marked in arrangements where a consultant was offered a fee per test commissioned

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<sup>752</sup> [www.chrt.org/public-policy/policy-papers/physician-ownership-in-hospitals-and-outpatient-facilities/](http://www.chrt.org/public-policy/policy-papers/physician-ownership-in-hospitals-and-outpatient-facilities/)

<sup>753</sup> Spire response to provisional findings, 11 November 2013.

or treatment delivered but less evident where rewards were based on the behaviour of a large pool of consultants.

- 8.162 However, we would expect that a clinician's decisions on choice of treatment would be less likely to be influenced by the types of schemes we have been discussing above than their recommendations on choice of facility. We would expect the ethical and regulatory constraints on consultant behaviour and, to the extent that it applies, peer or multidisciplinary team review, to offset to a substantial extent any economic incentive for a consultant to offer advice on treatment that was otherwise than in the patient's best interests. We would not rule out that on some occasions, some consultants might be influenced by economic incentives so as to overtreat, but we consider that such incidents are likely to be few and far between.
- 8.163 In respect of advice on diagnostic tests (blood tests, scans etc) commissioned, our view is that incentive schemes might have some influence on consultants' decisions as extra analyses of bloods already taken, for example, are completely non-invasive and others are minimally so. Incentives to conduct unnecessary diagnostic tests or consultations are therefore likely to have more effect on consultants' behaviour than incentives to overtreat. In our view, for some (probably very few) consultants, on some occasions, economic incentives are likely to result in unnecessary diagnostic tests or consultations.
- 8.164 We note that schemes which reward consultants in proportion to the volume or value of tests that they themselves commission are, now, less common. However, we are aware of schemes through which consultants share the profit from use of a single piece of, for example, imaging or radiotherapy equipment with a hospital operator. In this case, where an individual consultant's ownership stake is relatively large, the incentive properties of such an arrangement are closer to those of a referral fee than those of a reward scheme based on a large pool of participants, such as might operate at a private hospital offering a broad range of specialisms. Such schemes would seem to offer no patient benefit and it is also unclear that any benefits that may arise from such schemes in other contexts, such as encouraging investment in new equipment, outweigh their adverse effects.

## ***Findings***

- 8.165 We found that benefits and incentive schemes whose purpose was to encourage consultant referrals had been widely adopted by hospital operators, that all such schemes had the capacity to affect clinician conduct, but that some schemes appeared more likely to do so than others. Benefits of very low value, for example, including those made available to everyone, we concluded were unlikely to affect consultant conduct.
- 8.166 We found that direct benefits and incentive schemes were more likely than indirect schemes to affect competition adversely and that these are more likely to arise in the context of clinician advice on choice of private healthcare facility than choice of treatment.
- 8.167 We found that the capacity of indirect schemes to influence clinician conduct, in which we would include certain equity participation arrangements, varied with the extent to which an individual's incentives were diluted and with their value. We noted, however, that equity participation agreements were often accompanied by consultant commitments to practise at the facility concerned, in which case competition would be adversely affected, irrespective of caveats regarding the patient's best interests.

8.168 We therefore concluded that the existence of certain benefits and incentive schemes operated by private hospital operators which reward referring clinicians (directly or indirectly) for treating patients at, or commissioning tests from, their facilities are a feature in the provision of privately funded healthcare services by private hospital operators that gives rise to AECs in the markets for the provision of hospital services by private hospitals.

## 9. Information availability

### *Introduction*

9.1 In our overview of the private healthcare industry (see Section 2) we described various consumer ‘pathways’ to privately-funded healthcare. At certain points on these pathways, the consumer has to make choices: which consultant to see, which treatment option to follow and at which hospital to be treated. If the consumer lacks the necessary information to make these choices, or if information asymmetries exist, it is possible that market distortions may arise.

9.2 As the OFT pointed out in its Market Study:

accessible, standardized 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.<sup>754</sup>

9.3 In our annotated issues statement we posited (ToH6) that the privately-funded healthcare industry was characterized by both a lack of information and information asymmetries and that these may distort competition as they limit a patient’s ability to make an informed choice about the most appropriate hospital/consultant for their condition.

9.4 We said that we would be concerned if we identified financial or other incentives designed to capitalize or exploit any asymmetry, for example by private hospital operators offering incentives to consultants to refer patients to or use their facilities. We consider separately in Section 8 the effect on competition of incentives offered by private hospital operators to clinicians.<sup>755</sup>

9.5 We set out here the evidence we have examined, the analysis we have undertaken, the responses of the parties to the provisional findings and our conclusions on information availability and asymmetry in the following contexts:

- (a) choosing a consultant;
- (b) choosing a treatment option; and
- (c) choosing a private healthcare facility.

### *Choosing a consultant*

9.6 In this section, we consider what information is available to patients when choosing a consultant or, more commonly, considering the appropriateness of the consultant or consultants recommended to them by a GP (or their PMI). We look at (a) the current availability of information on consultants’ professional qualifications, areas of clinical expertise and fees and (b) the future availability of information on consultant performance based on clinical outcome data. We begin by setting out what the parties told us about the process of choosing a consultant.

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<sup>754</sup> [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).

<sup>755</sup> [www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/130603\\_hospital\\_competition.pdf](http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/130603_hospital_competition.pdf).



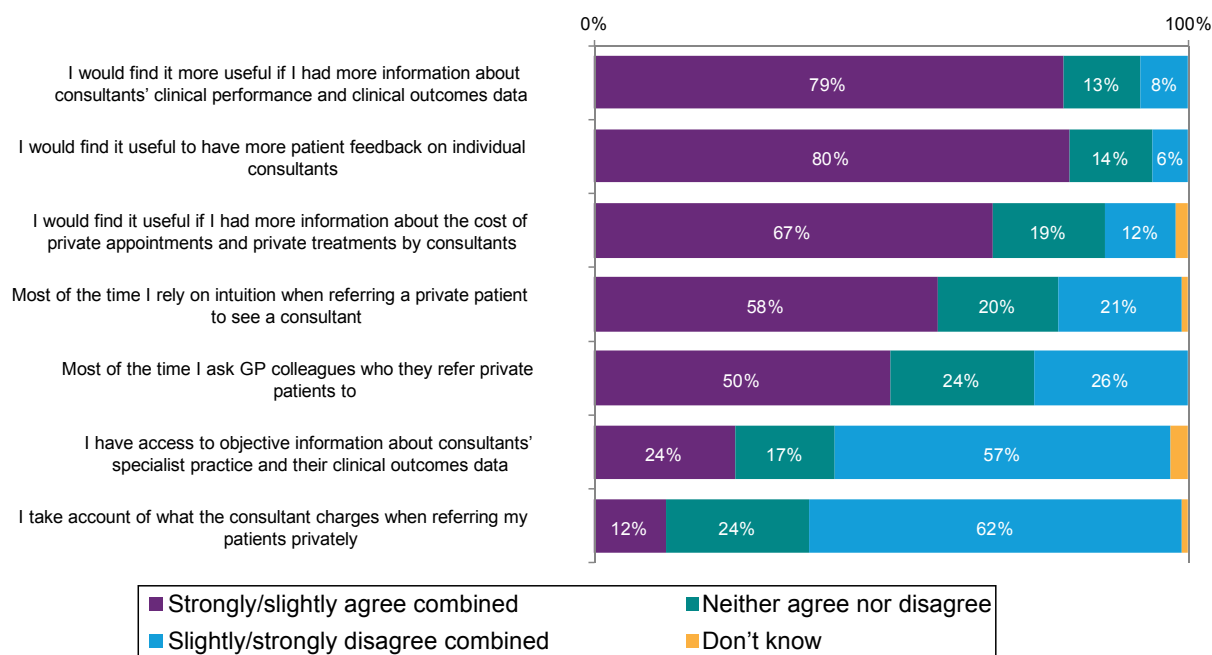
## What the parties told us

### PMIs

- 9.7 Bupa said that it had significant concerns that consultants (and hospitals) in private practice had failed to produce and make available data that allowed patients, GPs and insurers to evaluate and compare the quality of the treatments they performed and the care they offered, as well as the cost. It said that this gap in information put patients at risk and also created the perverse outcome that patients sometimes incorrectly assumed that price was a sign of quality. It told us that greater transparency of information was fundamental to empowering patients (and the commissioners of care on their behalf).
- 9.8 Bupa provided us with the results of a survey that it had conducted among GPs. This indicated that GPs would like more information about consultant performance and clinical outcomes, with half of those responding saying that they either relied on intuition when making a referral or asked a colleague for a recommendation.

FIGURE 9.1

### Bupa GP survey findings



Source: Bupa (KantarHealth Survey, December 2011/January 2012).

Note: Base: 397 GPs.

- 9.9 Aviva also said that there was clear asymmetry between the patient and the provider as regards the appropriateness, quality and price of various treatment options that might be available to the patient. It said that this asymmetry restricted the patient's (as well as the GP's and the PMI's) ability to make an informed choice about the most appropriate hospital/consultant. It said that while it recognized that healthcare information was often complex it was possible to provide information that patients could use and would find useful. It cited, for example, outcome and process measures relating to treatment conducted.
- 9.10 Aviva noted the importance of the GP in the early referral process and that the majority of patients followed the GP's recommendation. However, it said that it was

concerned that GPs were not well informed about the quality of consultants. A survey of GPs which it had conducted indicated that more GPs recommended a consultant on the basis of their reputation (77 per cent) than on the basis of their quality (7 per cent).

### *Private hospital operators*

- 9.11 HCA told us that it believed that all customers should be ‘informed customers’ and that it considered that the availability of a standard framework of quality information was vital to ensure that patients made an informed choice. It argued that patients should be able to choose consultants based on quality markers instead of being directed by their PMI, which might be more concerned about cost containment than quality or value. HCA highlighted that the algorithm used by BUPA to direct patients towards particular consultants was not transparent (to patients, GPs or consultants) and that BUPA had refused to release its methodology for independent professional review. It suggested that this lack of transparency might result in less innovation, quality and choice for patients.<sup>756</sup>
- 9.12 Ramsay said that it thought that information asymmetries were not as extreme as depicted by the CC and that current initiatives, for example the Private Healthcare Information Network (PHIN) project<sup>757</sup> (see further paragraph 9.62) would, in any case, solve the issue. It said that the surveys undertaken by the OFT indicated that patients and GPs were not as concerned by a lack of information as the CC had suggested.
- 9.13 Ramsay quoted the OFT’s patient survey which had explored patient attitudes to, for example, the number of procedures that a clinician had carried out or mortality rates among a consultant’s patients: ‘most [patients] did not feel equipped to assess such information and did not think it was necessary for the GP to provide this level of detail.’

### *Clinicians*

- 9.14 The Independent Doctors Federation (IDF) told us that GPs were generally in a good position to judge patient reported outcomes as well as monitoring any complications following treatment. The IDF submitted a number of letters from GPs highlighting that they referred patients to consultants taking into account a range of factors including, *inter alia*.<sup>758</sup>
- (a) the reputation of consultants, both clinical and in terms of the service provided to patients;
  - (b) consultants’ specific areas of expertise and their levels of experience;
  - (c) the personality of both the patient and the consultant; and
  - (d) consultants’ ability to communicate clearly with patients.
- 9.15 A number of the GPs who contacted us emphasized that they were better placed to advise patients on which consultant to choose than the employees of the PMIs. They noted that they had developed professional relationships with consultants in their

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<sup>756</sup> HCA response to provisional findings, paragraphs 9.4 & 9.36.

<sup>757</sup> [www.phin.org.uk/About.aspx](http://www.phin.org.uk/About.aspx).

<sup>758</sup> GP letters submitted by the IDF, September 2013.

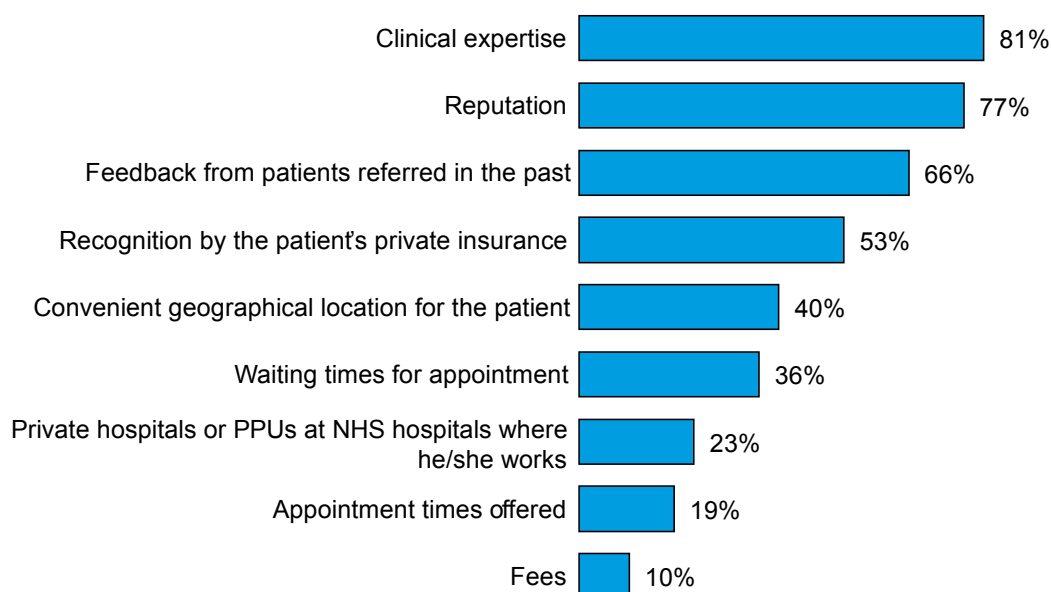
local areas through educational seminars taught by the local consultants, as well as via discussions within their practices of patient problems and sharing of knowledge.

## Our surveys

- 9.16 Our survey of patients<sup>759</sup> indicated that clinical expertise and reputation were the two most common reasons that respondents gave for choosing a consultant, specified by 38 per cent and 36 per cent of respondents respectively. Whether the PMI would cover their fees came reasonably close behind (29 per cent), though after the GP's recommendation (32 per cent) and the length of time the patient would have to wait for an appointment (32 per cent).
- 9.17 Roughly 60 per cent of patients did not know which consultant to see before they visited their GP. Just under one-third of respondents had sought information about a consultant's reputation or expertise and about half of these would have liked to have had more information but did not identify any specific information gaps.
- 9.18 Our survey of GPs indicated that clinical expertise was the single most important factor taken into account when choosing to which consultant to refer a patient, closely followed by reputation. Fees were considered to be the least important factor, with only 10 per cent of GPs stating that they took these into account.

FIGURE 9.2

### GPs' reported motivations for choosing consultants to which to refer patients



Source: GfK Survey of General Practitioners for the CC.

### Current and future information availability on consultants

- 9.19 General information about consultants, such as where they practise, their specialties, qualifications and professional memberships is easily obtainable from portals such as Dr Foster,<sup>760</sup> PMI websites,<sup>761</sup> hospital websites<sup>762</sup> or consultants' own websites.

<sup>759</sup> [www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/survey\\_patients\\_report.pptx](http://www.competition-commission.org.uk/assets/competitioncommission/docs/2012/private-healthcare-market-investigation/survey_patients_report.pptx).

<sup>760</sup> [www.drfoosterhealth.co.uk/consultant-guide/](http://www.drfoosterhealth.co.uk/consultant-guide/).

Some consultants include information on their fees for an initial and/or follow-up outpatient consultation on their personal websites, although they do not generally provide information on the price of treatments or surgery.<sup>763</sup>

9.20 There is a limited quantity of performance/outcome data for individual consultants available to patients and GPs in the UK.<sup>764</sup> The Society for Cardiothoracic Surgery in Great Britain and Northern Ireland was the first group to publish consultant-specific mortality rates following the 'Bristol Heart' scandal.<sup>765</sup> In mid-2013, NHS England (supported by the Healthcare Quality Improvement Partnership) started publishing similar consultant performance data in nine additional specialties, using data collected by consultants' professional bodies.<sup>766</sup> This was part of an initiative to improve the quality of healthcare provided.<sup>767</sup> The specialties and procedures covered by this data set include:

- (a) **adult cardiac surgery**: coronary artery bypass graft, valve surgery, aortic surgery, all cardiac surgery;
- (b) **vascular surgery**: abdominal aortic aneurism, carotid endarterectomy;
- (c) **thyroid and endocrine surgery**: thyroidectomy, lobectomy, isthmusectomy;
- (d) **bariatric surgery**: gastric bypass, gastric banding, sleeve gastrectomy;
- (e) **interventional cardiology**: percutaneous coronary intervention;
- (f) **orthopaedic surgery**: hip replacement, knee replacement;
- (g) **urological surgery**: nephrectomy;
- (h) **colorectal surgery**: bowel tumour removal;
- (i) **upper gastrointestinal surgery**: stomach cancer removal, oesophageal cancer removal; and
- (j) **head and neck cancer surgery**: larynx cancer removal, oral cavity cancer removal, oropharynx.

9.21 The data published shows how many times each consultant has performed a particular procedure, as well as each consultant's clinical outcomes benchmarked against the national average. In many cases, the clinical outcomes measured are mortality rates, although for some procedures other measures, such as unplanned returns to theatre or whether cancer surgery resulted in 'clear margins,'<sup>768</sup> are also provided. The data also highlights where a consultant's results differ in a statistically significant way from the national average. This initiative represents a substantial increase in the information available to GPs and patients, both private<sup>769</sup> and NHS.<sup>770</sup>

<sup>761</sup> For example, <http://finder.bupa.co.uk/>.

<sup>762</sup> For example, [www.hcahospitals.co.uk/our-specialists/](http://www.hcahospitals.co.uk/our-specialists/).

<sup>763</sup> However, package prices for self-pay patients, including consultant fees and hospital charges, can be found on the websites of hospitals participating in the PHIN project for a range of common treatments.

<sup>764</sup> [Where are we with transparency over performance of doctors and institutions?](#) by Aniket Taware BMJ 2012 345 (published 3 July 2012).

<sup>765</sup> [www.telegraph.co.uk/health/healthnews/7914795/Bristol-heart-scandal.html](http://www.telegraph.co.uk/health/healthnews/7914795/Bristol-heart-scandal.html); [www.scts.org/patients/](http://www.scts.org/patients/).

<sup>766</sup> [www.nhs.uk/choiceinthenhs/yourchoices/consultant-choice/pages/consultant-data.aspx](http://www.nhs.uk/choiceinthenhs/yourchoices/consultant-choice/pages/consultant-data.aspx).

<sup>767</sup> [Everyone Counts: Planning for Patients, 2013–2014](#).

<sup>768</sup> [www.cancerresearchuk.org/cancer-help/type/breast-cancer/treatment/surgery/types-of-breast-cancer-surgery](http://www.cancerresearchuk.org/cancer-help/type/breast-cancer/treatment/surgery/types-of-breast-cancer-surgery).

<sup>769</sup> The vast majority of consultants working privately also work in the NHS.

<sup>770</sup> [Can patients really make an informed choice: an evaluation of the availability of online information about consultant surgeons in the United Kingdom](#) by Sarkhell Saadi Radha et al, BMJ Open Access Medical Research, 20 March 2012.

- 9.22 The NHS in Scotland, Wales and Northern Ireland currently have no plans to publish comparable data to that published by the NHS in England, although a reasonably large proportion of the NHS England data on consultant performance also covers Wales and/or Scotland and Northern Ireland.

### ***Assessment—choosing a consultant***

- 9.23 As set out above, patients have ready access to information on consultants' areas of expertise, qualifications and professional memberships, although information on consultant fees remains more limited. Information on the performance of consultants (at least in their NHS practice) is increasingly available for patients and GPs in England, although not in the other nations.
- 9.24 We thought that GPs were well placed to advise patients on consultants' particular specialisms, level of experience, and 'soft skills'. In addition, we recognize that GPs can, to a certain extent, provide patients with advice on the clinical outcomes/performance of consultants. However, we considered that the advice provided by GPs (and PMIs) would benefit from being informed by a broader range of statistically-robust performance/clinical outcome measures. In particular, we thought that however experienced a GP was, they would only have insight into the performance of local consultants and would not easily be able to benchmark this against consultants nationally.
- 9.25 We considered that NHS England's initiative to publish consultant-level performance data represented a significant improvement in the availability of information. However, we thought that the limited nature of the data meant that it did not address the full range of information needs of patients. In addition, its focus on mortality rates, which were very low for many of the procedures listed, meant that it did not generally provide a reliable basis on which to distinguish between the large majority of consultants.
- 9.26 We reviewed the large number of consultant, GP and hospital operator complaints regarding the information provided by insurers to patients regarding consultants. We considered that in order to choose effectively between consultants, patients needed to understand clearly the basis on which an insurer was making a recommendation regarding which consultant to see, and concluded that there was some evidence that this was not currently the case.

### ***Choosing a treatment option***

#### ***Overview***

- 9.27 Information asymmetry is inherent in the consultant/patient relationship as it is in any professional/client relationship: consumers instruct professionals to perform tasks that they could not undertake themselves because they do not have the qualifications or experience to do so. Patients are entitled to expect, however, that their consultant, as their agent, will act in their, the principal's, best interests.
- 9.28 It was put to us by PMIs that, irrespective of the incentive schemes that hospital operators may adopt to encourage consultants to use their facilities (these are discussed in Section 8), the private medical sector's fee-for-service model may in itself create a tension between the consultant's duty to act in the patient's best clinical interest and their, the consultant's own, financial interest. Consultants and some of the private hospital operators, on the other hand, have argued that the PMIs

incentives operate in the opposite direction and that PMIs have an incentive to, in effect, 'under treat' patients.

- 9.29 In either circumstance, the patient may wish to test the advice that they have been given and will therefore need to seek information. We examine below whether information is available to patients that would enable them to do so.
- 9.30 We first set out the views that were put to us regarding clinical incentives arising from the fee-for-service model of private healthcare and how these might give rise to what have been described as 'unwarranted variations in treatment'.

### *What the parties told us*

#### *The PMIs*

- 9.31 Bupa told us that variation in treatments could signal market malfunction. It said that while variations in treatment could be clinically justified or explained by patient preference, it had observed wide variations in the way consultants and hospitals treated specific conditions in UK private healthcare, some of which amounted to 'unwarranted variation'. It said that such variation could harm patients, placing them at risk of unnecessary complications or death, and also affecting the cost of healthcare.
- 9.32 Bupa submitted a number of case studies which it said illustrated unwarranted treatment, one of which dealt with shoulder repair. It said that it had observed high levels of variation in two types of shoulder surgery to repair the rotator cuff muscle: arthroscopic acromioclavicular decompression and extensive open repair of rotator cuff muscles. Bupa told us that its members were [X] per cent more likely to receive the first treatment and [X] per cent more likely to receive the second treatment than comparable patients using the NHS. Bupa cited published articles advocating that initial treatment for rotator cuff damage should, in general, be non-surgical and quoted the American Academy of Orthopaedic Surgeons to the effect that patients with rotator cuff-related symptoms, in the absence of full thickness tear, should be initially treated non-operatively, using exercise and/or non-steroidal anti-inflammatory drugs.
- 9.33 In response to the provisional findings, Bupa argued that there was no evidence that the NHS routinely undertreated patients and hence was not an appropriate comparator for the private sector. It emphasized that the evidence that it submitted on knee arthroscopies, for example, compared private practice with the most interventionist NHS primary care trusts, rather than the NHS average. It argued that this gave significant credibility to its concerns regarding overtreatment. Bupa told us that the significant and sustained reductions in the number of requests for both knee arthroscopies and wisdom tooth extractions following its introduction of a requirement that consultants explain, in advance of treatment, why the treatment was necessary, provided further evidence of unwarranted variation in treatment in the private sector.<sup>771</sup>

#### *Hospital operators*

- 9.34 Hospital operators generally argued that PMIs, where they had introduced guidance into their processes, were at least partially influenced by commercial considerations.

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<sup>771</sup> BUPA response to provisional findings, paragraphs 5.3–5.13.

HCA, for example, drew our attention to the many submissions made to us by individual consultants which raised concerns about managed care in general and Bupa's open referral process in particular. It said that these contained many specific complaints that, although a particular consultant had been recommended on clinical grounds to treat a particular patient, the PMI had redirected patients to lower-cost providers. HCA expressed concern that where PMIs gave guidance on treatment options, this may be influenced by commercial considerations rather than the best medical interests of the patient.<sup>772</sup>

- 9.35 Spire told us that arguments to the effect that private healthcare providers had an incentive to 'overtreat' patients, using comparisons of practice in the NHS and the private healthcare sector, could be misleading. It told us that there was a risk that publicly-funded capitation models such as the NHS in the UK faced incentives to 'undertreat' and that the level of treatment available in the NHS may not be an appropriate point of comparison for the level of treatment available in private facilities. Spire also highlighted that it had extensive clinical governance structures in place to prevent either over- or undertreatment by consultants.

#### *Clinicians*

- 9.36 The BMA told us that managed care initiatives disrupted traditional, clinically proven referral processes and treatment pathways. It said that decisions were often based on what was deemed cost-effective, or what was allowed under the patient's insurance policy, rather than what was clinically appropriate.
- 9.37 The British Orthopaedic Association made a similar submission to HCA's, citing in particular Bupa reviews of consultant decisions, which it said were entirely motivated by commercial objectives and which were causing severe patient detriment.
- 9.38 FIPO too made similar points, again in the context of musculoskeletal conditions. It cited the Bupa by You option of an initial consultation for a patient with back pain with a physiotherapist as indicating that such modifications to the referral mechanism may not be dictated by the patient's best interest.
- 9.39 As noted above, we received many letters from individual consultants which included references to PMI-managed care processes suggesting that they may result in inappropriate treatment for patients. We present a summary of these letters in Appendix 7.3.

#### *Information available on treatment options*

- 9.40 We review here information sources on treatment options which, while they are mainly provided by the NHS, are also available to private patients.

#### *National Institute for Health and Care Excellence clinical guidelines*

- 9.41 NICE produces clinical guidelines with recommendations on the appropriate treatment and care of people with specific diseases and conditions. They are based on available evidence and developed in association with the Royal Medical, Nursing and Midwifery Colleges. In general, healthcare workers in the NHS in England and Wales are expected to follow NICE's clinical guidelines. The Scottish Intercollegiate Guidelines Network (SIGN) is responsible for developing evidence-based clinical

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<sup>772</sup> [HCA response to provisional findings](#), paragraph 9.30.



practice guidelines for the NHS in Scotland. NICE and SIGN have signed a Memorandum of Understanding, setting out how they work together.<sup>773</sup> In Northern Ireland, the Department for Health Social Services and Public Safety has a formal link with NICE under which the latter's guidance is reviewed for its applicability to Northern Ireland and, where found to be applicable, is endorsed by the Department.<sup>774</sup>

- 9.42 NICE has produced 168 clinical guidelines and more than 60 guidelines are in development. Topics are referred to NICE by the DoH. Topics are selected on the basis of a number of factors, including the burden of disease, the impact on resources and whether there is inappropriate variation in practice across the country.<sup>775</sup>
- 9.43 Most guidelines aim to support clinicians but NICE also produces versions of its clinical guidance written for the public to help patients make informed decisions. These versions summarize the recommendations that NICE makes using suitable language for people without specialist medical knowledge: for example, a NICE guideline describes the various options for patients with prostate cancer together with questions the patient should consider themselves or ask their doctor.<sup>776</sup>

### *NHS Choices*

- 9.44 NHS Choices is funded by the DoH and describes itself as 'the UK's biggest health website'<sup>777</sup> receiving, in the first quarter of 2013, an average of over 25 million visits a month.<sup>778</sup> NHS Choices includes detailed information about common diseases and conditions and treatments on its publicly available website and contains links to other relevant NHS sites such as Choose and Book, as well as NICE Guidance and a range of other sources of information and support for patients.<sup>779</sup>
- 9.45 The website also contains openly accessible advice to clinicians, through 'maps of medicine'. We show below the 'map' for shoulder pain where the clinician considers this may arise from rotator cuff damage.

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<sup>773</sup> [www.sign.ac.uk/about/niceandsign.html](http://www.sign.ac.uk/about/niceandsign.html).

<sup>774</sup> [www.dhsspsni.gov.uk/sqsd-guidance-nice-guidance](http://www.dhsspsni.gov.uk/sqsd-guidance-nice-guidance);

[www.dhsspsni.gov.uk/circular\\_hsc\\_sqsd\\_04\\_11\\_nice\\_guidelines\\_8211\\_new\\_process.pdf](http://www.dhsspsni.gov.uk/circular_hsc_sqsd_04_11_nice_guidelines_8211_new_process.pdf).

<sup>775</sup> A list of published clinical guidelines can be found at <http://guidance.nice.org.uk/CG/Published>.

<sup>776</sup> [www.nice.org.uk/nicemedia/live/12352/51299/51299.pdf](http://www.nice.org.uk/nicemedia/live/12352/51299/51299.pdf).

<sup>777</sup> [www.nhs.uk/aboutNHSChoices/Pages/NHSChoicesintroduction.aspx](http://www.nhs.uk/aboutNHSChoices/Pages/NHSChoicesintroduction.aspx).

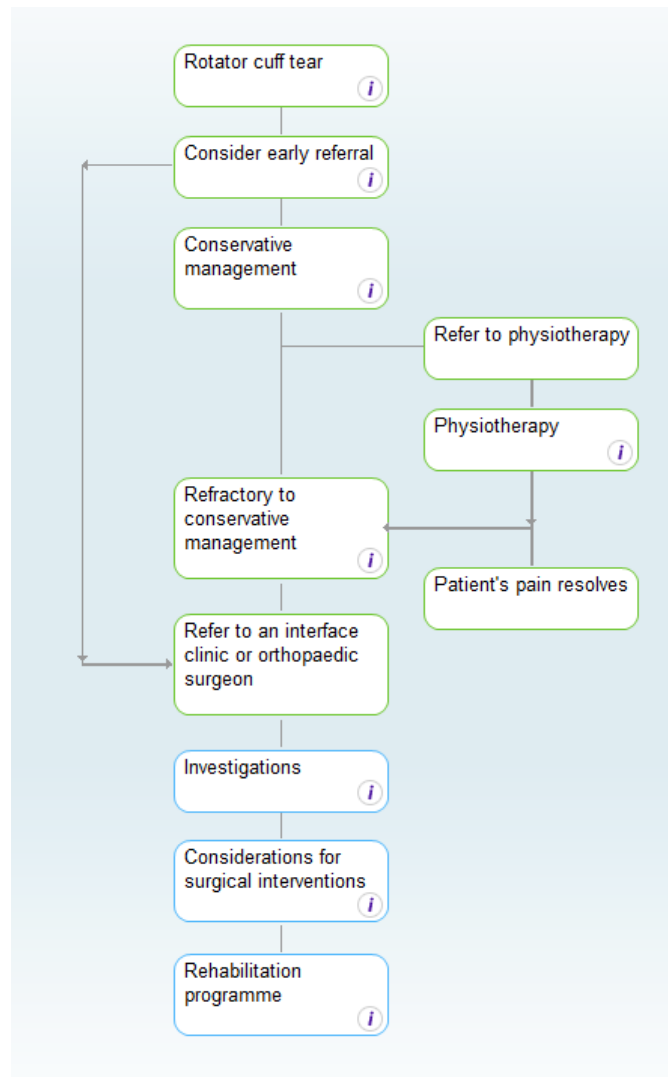
<sup>778</sup> [www.nhs.uk/aboutNHSChoices/professionals/developments/Pages/Preformancestatistics.aspx](http://www.nhs.uk/aboutNHSChoices/professionals/developments/Pages/Preformancestatistics.aspx).

<sup>779</sup> These include links to various charities which provide information and support to those suffering from various illnesses, such as Macmillan cancer support, and specialist colleges and institutes, such as the Chartered Society of Physiotherapy.



FIGURE 9.3

### Map of medicine for shoulder pain



Source: NHS Choices.

### Patient decision aids

- 9.46 Patient decision aids are similar to clinical guidelines, in that they are based on research evidence, but they are designed not just to inform patients, but to help them think about what the different options might mean for them and to reach an informed preference. They are also designed to emphasize the principle that there should be 'no decision about me, without me'.<sup>780</sup>
- 9.47 Patient decision aids take a variety of forms, spanning everything from simple one-page sheets outlining the choices, through more detailed leaflets or computer programmes, to DVDs or interactive websites that include filmed interviews with patients

<sup>780</sup> [www.kingsfund.org.uk/publications/making-shared-decision-making-reality](http://www.kingsfund.org.uk/publications/making-shared-decision-making-reality).

and professionals, enabling the viewer to delve into as much or as little detail as they want.<sup>781</sup>

- 9.48 Decision aids for 38 conditions were developed by the Right Care Programme, a workstream of the DoH's Quality, Innovation, Productivity and Prevention (QIPP) programme for the NHS in England.<sup>782</sup> These decision aids are available on the Right Care website<sup>783</sup> and mimic the exchanges between clinician and patient that would take place through a process of shared decision making (SDM).<sup>784</sup> The guides take a patient through various stages of the decision process, enabling them, for example, to access additional information at various stages if they wish to do so.
- 9.49 The Health Foundation, an independent charity with the mission of improving the quality of healthcare in the UK, is sponsoring the Making Good Decisions In Collaboration (MAGIC) project which is exploring how SDM can be embedded into mainstream clinical practice. Initial trials of the programme are being undertaken in NHS hospitals in Newcastle and Cardiff.<sup>785</sup>

#### *PMIs websites*

- 9.50 Most of the larger PMIs provide a range of information to patients on their websites, or via call centres. Bupa's website has a directory of over 600 healthcare topics, which provide information ranging from general lifestyle advice, to detailed descriptions of illnesses and treatment options.<sup>786</sup> In addition, Bupa operates a 'Treatment Options Service', which is a call centre staffed by qualified nurses, who discuss the various treatment options that may be available to Bupa policyholders following their diagnosis.<sup>787</sup> Similarly, AXA PPP's website provides factsheets on a broad range of medical conditions, the information for which is supplied by NHS Choices. AXA PPP policyholders also have access to its panel of medical experts, to whom they are able to submit questions via the website.<sup>788</sup>

#### *Private hospitals' websites*

- 9.51 Patients are also able to access some information on the most common treatments from the websites of the private hospitals. For example, BMI's website provides information on how a specific procedure is performed, what a patient should expect before, during and after surgery, the potential complications associated with a treatment as well as potential alternative treatments which may be appropriate for a given illness.<sup>789</sup> Spire, Nuffield, Ramsay and HCA provide similar information on their websites, although in some cases the information is limited to a description of the procedure and the recovery, rather than a fuller discussion of treatment options.<sup>790</sup>

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<sup>781</sup> [www.kingsfund.org.uk/publications/making-shared-decision-making-reality](http://www.kingsfund.org.uk/publications/making-shared-decision-making-reality).

<sup>782</sup> NHS Scotland has included shared decision making as a goal in its Healthcare Quality Strategy published in May 2010. See [www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf](http://www.scotland.gov.uk/Resource/Doc/311667/0098354.pdf).

<sup>783</sup> <http://sdm.rightcare.nhs.uk/pda>.

<sup>784</sup> [www.kingsfund.org.uk/publications/making-shared-decision-making-reality](http://www.kingsfund.org.uk/publications/making-shared-decision-making-reality).

<sup>785</sup> [www.bmj.com/content/341/bmj.c5146](http://www.bmj.com/content/341/bmj.c5146); <http://www.health.org.uk/public/cms/75/76/313/4173/MAGIC%20evaluation.pdf?realName=J1N5Vk.pdf>

<sup>786</sup> See: [www.bupa.co.uk/individuals/health-information/directory/b/hi-breast-cancer?#textBlock192475](http://www.bupa.co.uk/individuals/health-information/directory/b/hi-breast-cancer?#textBlock192475).

Aviva also offers a variety of health and treatment information to patients, see: [www.aviva.co.uk/health-insurance/home-of-health/](http://www.aviva.co.uk/health-insurance/home-of-health/).

<sup>787</sup> [www.bupa.co.uk/members/members-health-insurance/members-treatment/treatment-options-service](http://www.bupa.co.uk/members/members-health-insurance/members-treatment/treatment-options-service).

<sup>788</sup> [www.axapphealthcare.co.uk/health-information/meet-the-experts/](http://www.axapphealthcare.co.uk/health-information/meet-the-experts/).

<sup>789</sup> [www.bmihealthcare.co.uk/treatment/treatmentsdetail?p\\_treatment\\_name=Hip%20replacement%20surgery&p\\_treatment\\_id=304](http://www.bmihealthcare.co.uk/treatment/treatmentsdetail?p_treatment_name=Hip%20replacement%20surgery&p_treatment_id=304).

<sup>790</sup> [www.spirehealthcare.com/our-treatments/body-map-and-a-z/a-z-treatments/](http://www.spirehealthcare.com/our-treatments/body-map-and-a-z/a-z-treatments/); [www.nuffieldhealth.com/hospitals/tests-and-treatments/treatments](http://www.nuffieldhealth.com/hospitals/tests-and-treatments/treatments); <http://www.ramsayhealth.co.uk/treatments>; <http://www.hcahospitals.co.uk/treatments/a-z-of-services-and-treatments/>.

## ***Assessment—choosing a treatment option***

- 9.52 PMIs put it to us that the incentives inherent in the private healthcare's fee-for-service model, coupled with the patient's lack of information on treatment options gave rise to overtreatment. Clinicians, and some private hospital operators, told us that PMIs, by adopting open referral processes, were making it more probable that undertreatment would result.
- 9.53 We think that it would be extremely hard to quantify the extent of over- (or under-) treatment in privately-funded healthcare not least given, for example, the difficulty of identifying an appropriate benchmark.
- 9.54 Some of the evidence put to us made comparisons between practice in the NHS and in private healthcare, for example. In the provisional findings, we highlighted that we did not consider that NHS practice was necessarily an appropriate benchmark since its taxpayer-funded provided an incentive to minimize the cost of treatment and to ration the number of treatments performed. For example, certain procedures might rarely be performed under general anaesthetic within the NHS on cost grounds even if patients would prefer this. More generally, we observe that there is evidence that the NHS is placing limits on the volumes of certain procedures undertaken in order to meet its budget constraints.<sup>791</sup>
- 9.55 We considered Bupa's argument that certain variation in treatment levels may be 'unwarranted' which would potentially indicate that consultants and/or hospitals were exploiting the information asymmetries between themselves and patients. However, we reasoned that, given the evidence of significant variation in intervention rates across NHS primary care trusts, a proportion of which was also acknowledged to be 'unwarranted',<sup>792</sup> it could not be shown that the variation observed by the PMIs was the direct result of the fee-for-service model and the exploitation of information asymmetries by clinicians. We thought that Bupa's actions in relation to knee arthroscopies and wisdom tooth extraction indicated that the PMIs did have means to (at least partly) counteract variation which was unwarranted.
- 9.56 Our (albeit limited) review suggests that patients have access to a significant quantity of information to help them understand the treatment options available to them, which should allow them to engage in an informed discussion with their consultant regarding these options. However, we note that this type of information does not fully eliminate the information asymmetry between the patient and consultant. The patient will necessarily remain reliant on the consultant for the diagnosis of their specific condition. For example, in the case of a torn rotator cuff, a patient has access to information indicating that for a mild tear physiotherapy may be recommended, whereas for a more serious tear surgery may be necessary. However, the patient must rely on their consultant to diagnose the severity of their rotator cuff tear.
- 9.57 Furthermore, we recognize that, while a significant quantity of information on treatment options may be available to patients, they may not currently be making use of it. Our survey indicated that only 9 per cent of patients had sought information on the procedure or treatment that they received. This implies that a large proportion of patients rely on their consultant's recommendation regarding treatment options.

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<sup>791</sup> [www.bbc.co.uk/news/health-25219008](http://www.bbc.co.uk/news/health-25219008).

<sup>792</sup> [www.rightcare.nhs.uk/index.php/atlas/atlas-of-variation-2011/](http://www.rightcare.nhs.uk/index.php/atlas/atlas-of-variation-2011/).

## ***Choosing a private healthcare facility***

- 9.58 We now look at what information is available to consumers on the cost, facilities and service quality of private healthcare facilities.<sup>793</sup>

### ***Information available currently***

- 9.59 Information on the facilities provided by private hospitals, including the treatments they offer, the consultants they use and the facilities they provide, is readily available from their websites. Equally, and particularly since the PHIN initiative discussed below, the cost of their services is reasonably transparent for self-pay patients. However, information on hospital performance is less readily available.
- 9.60 Private hospital operators have, historically, provided a limited amount of information on their hospitals' performance on portals such as Dr Foster and NHS Choices as well as their own websites. This has included statistics on patient satisfaction and MRSA and C. Difficile infection rates, for example.
- 9.61 In addition to information provided by the private hospital operators, patients are also able to access information on hospital quality from the healthcare regulators in England, Wales, Scotland and Northern Ireland. These are the CQC, Healthcare Inspectorate Wales, Healthcare Improvement Scotland and the Regulation and Quality Improvement Authority, respectively. These regulators inspect all hospitals, both NHS and private, and evaluate them against a range of criteria, from infection control procedures to respecting patients' dignity and human rights.<sup>794</sup> Each regulator uses slightly different criteria, although there is significant overlap in the quality measures taken into account. During the course of our investigation, private hospital operators launched a new initiative to make information on private hospitals available to patients. PHIN, a not-for-profit member organization open to all independent hospital operators, superseded the collaborative Hellenic Project begun in 2009 by the main hospital groups,<sup>795</sup> with, it told us, improved resources, governance and breadth of participation. PHIN told us that it intended to publish standardized and directly comparable information which would allow patients and doctors to search for local hospitals by procedure and to compare how they perform based on treatment data of more than 1 million patients a year. The website<sup>796</sup> launched at the end of April 2013 with information including, for example, the frequency with which particular procedures were undertaken at the hospital concerned, the distribution of lengths of stay and, in some cases, patient reported outcome measures (PROMs) information relating to NHS patients treated at private hospitals.<sup>797</sup>
- 9.62 PHIN told us that it aimed, within a planned timetable, to collect and publish information relating to the treatment of all patients (private and NHS-funded) at all independent hospitals in the UK, benchmarked against the NHS wherever possible. PHIN told us that it currently published data from 11 provider organizations comprising 194 hospitals, with seven more providers at various stages of joining. Publication of data is based on Private Hospital Episode Statistics (PHES) collected by PHIN from its members, with the intention that this dataset be equivalent to the

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<sup>793</sup> In this section we use 'hospital' or 'private hospital' to refer to any private healthcare facility providing medical treatments, whether inpatient day-case or outpatient. References to hospital or private hospital should be read accordingly.

<sup>794</sup> For an example of an inspection report for the London Bridge Hospital, see [www.cqc.org.uk/directory/1-126955902](http://www.cqc.org.uk/directory/1-126955902).

For an example of an inspection report for Spire Yale, see

[www.hiwi.org.uk/Documents/477/Inspection%20Report%20Spire%20Yale%20English%202010.pdf](http://www.hiwi.org.uk/Documents/477/Inspection%20Report%20Spire%20Yale%20English%202010.pdf).

<sup>795</sup> Including BMI, HCA, Spire, Ramsay and Nuffield.

<sup>796</sup> [www.phin.org.uk/about.aspx](http://www.phin.org.uk/about.aspx)

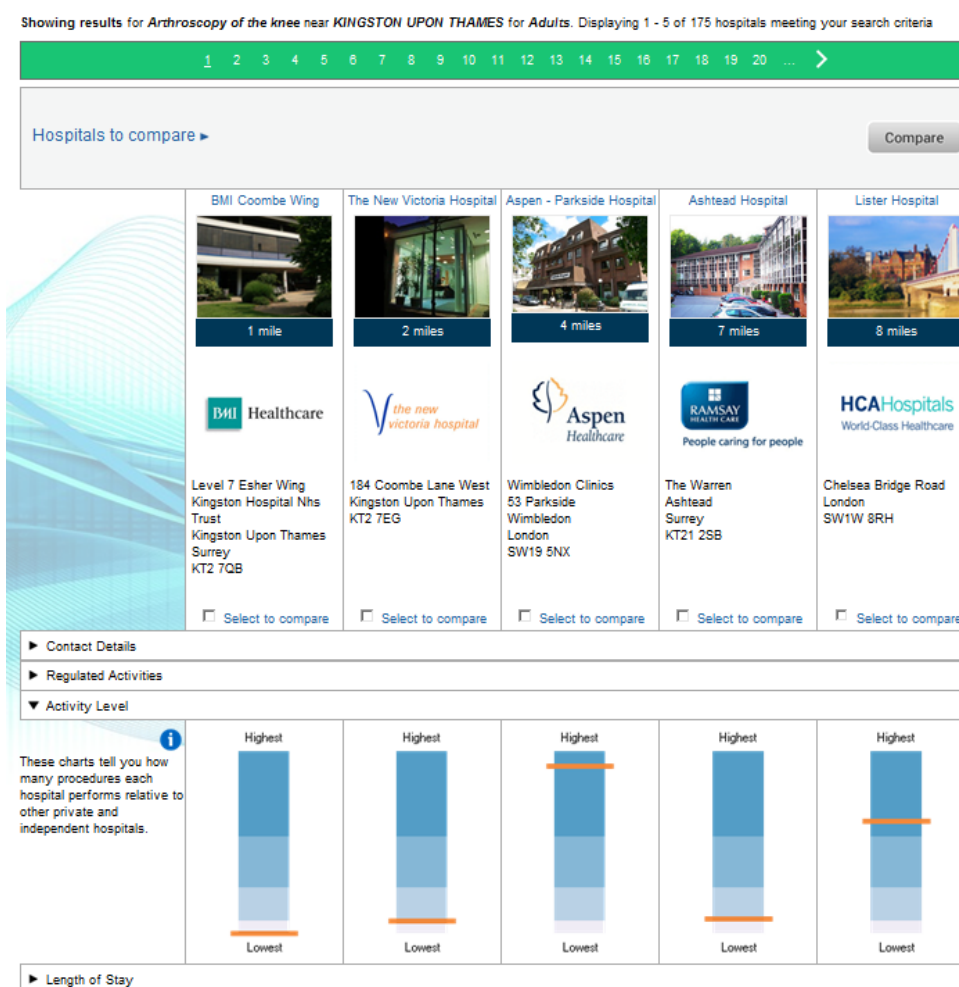
<sup>797</sup> PROMs information is limited to hip and knee replacements.

HES data collected in England by HSCIC<sup>798</sup> on all NHS patients whether they are treated at a private or an NHS hospital. PHIN combines PHES and relevant HES data to produce Independent Hospital Episode Statistics (IHES) to give a picture of the quality of service available in private hospitals.<sup>799</sup>

- 9.63 HSCIC also collects, again solely in England, PROMs for hip and knee surgery. PHIN told us that it would publish PROMs data relating to private patients from its member organizations that currently collected it.
- 9.64 We show in Figure 9.4 below the first page results of a sample search, for hospitals offering knee arthroscopy centered on Kingston, Surrey. This shows how frequently the procedure is carried out at the identified hospitals which are ranked ordered by distance from the postcode used in the search. It can also display the number of nights a patient could expect to be in hospital for this procedure though only the BMI PPU involves an overnight stay.

FIGURE 9.4

### PHIN sample search results



Source: PHIN.

<sup>798</sup> Health and Social Care Information Centre: [www.hscic.gov.uk/](http://www.hscic.gov.uk/).

<sup>799</sup> PHIN told us that it collects and publishes data from other NHS and private sources beyond IHES data, including PROMs, the NHS Friends and Family Test, the National Joint Registry and infections data from Public Health England.

- 9.65 PHIN told us that it intended to increase significantly the range of information on the website, and had a program in place to publish more extensive data relating to a greater number of comparators over the next three months to one year. PHIN told us that in addition to launching further clinical quality indicators, it intended to introduce an IHES analytical tool for members aimed at improving use of information, and to publish reports looking at specialty areas such as cancer services and cosmetic surgery services in detail.

### *Hospital operators' views*

- 9.66 HCA highlighted the same concerns in relation to the PMI's use of guided treatment pathways in respect of choosing a hospital as for choosing a consultant (see paragraph 9.11). It put forward the view that, through PHIN, the industry had made significant progress towards improving the availability and quality of information about clinical outcomes. HCA emphasized that, in a competitive market, quality was a key differentiator and driver of commercial success and that for hospital operators to compete as effectively as possible on quality, it was important that patients' decisions on where to seek treatment were based on reliable information on similar process and outcome indicators.<sup>800</sup>
- 9.67 HCA highlighted its key role in funding and leading an industry-wide initiative to develop a common online presentation format for the prices of over 70 per cent of self-pay procedures. It noted that by June 2013, all six of the largest hospital groups had published the majority of their self-pay prices in the common format on their websites.<sup>801</sup>
- 9.68 Ramsay said it believed that the PHIN project would, in the very near future, deliver information on private hospitals equivalent to, if not more comprehensive than, that available on NHS hospitals. In addition Ramsay noted that the private hospitals participating in PHIN had engaged in a process by which each operator would publish indicative tariffs for a set of self-pay procedures in a format that was consistent and comparable. This was launched in early June 2013. Spire told the CC that it was supportive of current initiatives to provide additional quality information to patients, both via PHIN and through its own website, highlighting its recent publication of PROMs data, as well as readmission rates and a number of other quality benchmarks.

### *PMIs' views*

- 9.69 There was general agreement among the PMIs that more information on private hospital quality and performance would be desirable.
- 9.70 Bupa said that, like the CC, it saw no reason why performance and outcome data on private hospitals should not be comparable with that available for NHS hospitals. Aviva set out additional information that it would like to see published and explained the use that it would make of it. The information it would wish to see available included safety data (for example, concerning the incidence of MRSA), access information (whether the patient was given a choice of dates) and information on the patient experience (for example last-minute cancellations).

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<sup>800</sup> [HCA response to provisional findings](#), paragraphs 9.8 & 9.9.

<sup>801</sup> *ibid*, paragraph 9.17.



### *Assessment—choosing a private healthcare facility*

- 9.71 In some parts of the UK patients have little or no choice of private healthcare facility for many medical treatments. Even where patients have a choice, however, there has been little consistent and readily comparable data on performance on anything like the range of indicators and metrics available for NHS hospitals. Nor have private hospitals collected or reported to the CQC (or other regulators in the nations) HES data,<sup>802</sup> other than in respect of NHS patients that they treat at their hospitals. Such data could provide an input to and help prioritize the CQC's (and other regulators in the nations) risk-based inspection programme or possible hospital rating system.
- 9.72 The PHIN project aims to address the lack of a consistent and comprehensive dataset on private hospital performance, and PHIN has told us that it aims to deliver performance information comparable to that collected and published for NHS hospitals using a phased-in approach. In order to make the data comparable to NHS and international benchmarks, it may be necessary for the industry as a whole to standardize certain aspects of data collection, for example the coding of activity and impairment data. In this respect, we note that a recent contract signed between HCA and Bupa stated that [✂].<sup>803</sup>

### **Conclusions**

- 9.73 We considered information availability and asymmetry in three contexts:

- (a) choosing a consultant;
- (b) choosing a treatment option; and
- (c) choosing a private healthcare facility.

### *Choosing a consultant*

- 9.74 We took the view that for competition between consultants to function well, patients would need to know, in addition to the consultant's fee structure, information about the consultant's qualifications, areas of expertise, extent of experience and performance.
- 9.75 We found that information on the qualifications and specialisms of consultants was readily available across the UK via private and NHS hospital websites, portals such as Dr Foster, GPs and the consultants' own websites, although information on consultant fees remains more limited.
- 9.76 NHS England has recently published individual consultant performance data in ten specialisms, with plans to extend this initiative significantly over the next few years.<sup>804</sup> We understand that no equivalent programmes to disclose consultant performance information are envisaged for the rest of the UK.
- 9.77 We could not be sure when or whether the remaining consultant performance data which it is envisaged will be disclosed in England will appear, nor whether plans to

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<sup>802</sup> [www.hscic.gov.uk/hes](http://www.hscic.gov.uk/hes).

<sup>803</sup> A description of the ICD 10 coding system is set out on the World Health Organisation website: [www.who.int/classifications/icd/en/](http://www.who.int/classifications/icd/en/).

<sup>804</sup> In particular, NHS England plans to include a broader range of specialties and procedures in the dataset. [www.nhs.uk/choiceintheNHS/Yourchoices/consultant-choice/Pages/consultant-data.aspx](http://www.nhs.uk/choiceintheNHS/Yourchoices/consultant-choice/Pages/consultant-data.aspx).

disclose the same or analogous information in Scotland, Wales and Northern Ireland will emerge. Moreover, we thought that the data published by NHS England, while useful, would not represent a comprehensive solution to the current lack of performance information on consultants. In particular, we were concerned that the majority of this information focuses on mortality rates, which can be very low for many of the procedures listed, making them an unreliable basis on which to distinguish between consultants. We thought that a broader range of outcome measures would be necessary to facilitate patient choice.

- 9.78 In addition, we were concerned that there was evidence to suggest that some PMIs were not currently being explicit with patients regarding the basis on which they were recommending or not recommending a particular consultant. For a patient to make an informed choice, they must understand whether a recommendation is based on cost or quality.
- 9.79 We therefore conclude that a lack of sufficient independent, publicly available performance and fee information on consultants prevents the proper functioning of competition between consultants and is a conduct feature in the provision of privately funded healthcare services by consultants. This feature gives rise to an AEC in the provision of consultant services across the UK.

### *Choosing a treatment option*

- 9.80 Whilst we acknowledged that information asymmetry between consultant and patient was inevitable, we consider that, in order for competition between consultants and between consultants and alternative healthcare pathways to function properly, patients should have access to information on the comparative benefits of different treatment options.
- 9.81 We found that patient information on treatment options was readily available across the UK. Our conclusion is, therefore, that a lack of patient information on treatment options is *not* a feature of the private healthcare market giving rise to an AEC.

### *Choosing a private healthcare facility*

- 9.82 Information on the performance of private healthcare facilities has been poor in the past and below the standard of the information available on NHS hospitals. During the course of our investigation a fresh initiative (PHIN) was launched to improve the quality of information that is available to patients.
- 9.83 Whilst this information is expected to improve in terms of healthcare facility coverage and range of indicators, we conclude that, at present, it is insufficient to promote competition between private healthcare facilities. We therefore conclude that the lack of publicly available information on the performance of private healthcare facilities is a conduct feature in the provision of privately funded healthcare services. This feature gives rise to AECs in the provision private healthcare services across the UK.



## 10. Our findings regarding an AEC

- 10.1 As described in paragraph 1.1, on 4 April 2012, the OFT made a market investigation reference to the CC under sections 131 and 133 of the Act regarding the supply or acquisition of privately-funded healthcare services in the UK. Section 134(1) of the Act requires us to decide whether ‘any feature, or combination of features, of each relevant market prevents, restricts or distorts competition in connection with the supply or acquisition of goods or services in the United Kingdom or a part of the United Kingdom’. If that proves to be the case, under the Act, this constitutes an AEC.
- 10.2 For the reasons given in Sections 6, 8 and 9, we identified that there are a number of structural and conduct features in the provision of privately-funded healthcare services in the UK which either individually or in combination give rise to AECs.
- 10.3 We found two structural features in the provision of privately-funded healthcare services by private hospital operators:
- (a) high barriers to entry and expansion for private hospitals; and
  - (b) weak competitive constraints exerted on private hospitals in many local markets including central London.
- 10.4 In order to make a decision that a feature, or combination of features, of a relevant market prevents, restricts or distorts competition and constitutes an AEC, the decision must be that of at least two-thirds of the Inquiry Group.<sup>805</sup> Where, as here, an Inquiry Group comprises five members this requires that four members of the Inquiry Group must make the AEC decision.
- 10.5 In combination, the features set out in paragraph 10.3 above give rise to AECs in the markets for the provision of hospital services which lead to higher prices for inpatient and some day-case and outpatient hospital services to self-pay patients at private hospitals in local markets which are subject to weak competitive constraints across the UK, including in central London. Together, these features also give rise to AECs in the markets for the provision of hospital services which lead to higher prices being charged by HCA to PMIs across the range of treatments for insured patients in central London.
- 10.6 As set out in paragraphs 6.493 to 6.494, three members of the Inquiry Group found that the combination of the features set out in paragraph 10.3 above lead to higher prices being charged by BMI, Spire and Nuffield to PMIs for the range of treatments for insured patients outside central London. However, these members did not consist of two-thirds of the Inquiry Group. Our decision, therefore, is that these features do not give rise to AECs in the markets for the provision of hospital services by BMI, Spire or Nuffield to PMIs for the treatment of insured patients outside central London.
- 10.7 We found that the existence of certain benefits and incentive schemes operated by private hospital operators which (directly or indirectly) reward referring clinicians for treating patients at, or commissioning tests from their private healthcare facilities, was a conduct feature in the provision of privately-funded healthcare services by private hospital operators. This feature gives rise to AECs in the markets for the provision of hospital services by private hospital operators across the UK due to the

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<sup>805</sup> Paragraph 20(5) of [Schedule 7](#) Competition Act 1998 as amended.

distortion of referral decisions to their private healthcare facilities and the distortion of patient choice of diagnosis and treatment options.

- 10.8 We found that the lack of publicly available performance information on private healthcare facilities was a conduct feature in the provision of privately-funded healthcare services by private healthcare facilities. This feature gives rise to an AEC in the provision of private healthcare services across the UK due to the distortion of competition between private healthcare facilities by preventing patients from exercising effective choice in selecting the private healthcare facilities at which to be treated. This reduces competition between private healthcare facilities on the basis of quality and price.
- 10.9 We found that the lack of independent publicly available performance and fee information on consultants was a conduct feature in the provision of privately-funded healthcare services by consultants. This feature gives rise to an AEC in the provision of consultant services across the UK due to the distortion of competition between consultants by preventing patients from exercising effective choice in selecting the consultants by whom to be diagnosed and treated. This reduces competition between consultants on the basis of quality and price.
- 10.10 We have produced an estimate of the consumer detriment resulting from the market power of the three largest private hospital operators (BMI, HCA and Spire) using the profitability analysis. This analysis was based on the private hospital activities of the relevant firms.<sup>806</sup> As NHS services are outside the scope of our reference, we have sought to exclude them from our estimate of detriment. Our estimate apportions EBIT and capital employed between NHS and private work in proportion to the revenue earned from each source. We then calculate the difference between the ROCE and the cost of capital (taken to be 10 per cent).
- 10.11 On this basis, our estimate of the consumer detriment resulting from the three largest private hospital operators is between £155 million and £174 million per year between 2009 and 2011, which is equivalent to around 10 per cent of the total private revenues of these firms (BMI, HCA and Spire). We consider that this represents a conservative estimate of the consumer detriment for the following reasons:
- (a) NHS revenue generates a lower margin than private revenue, hence a larger proportion of EBIT will relate to private patients than we have estimated in our analysis;
  - (b) we have used a cost of capital of 10 per cent, which is towards the upper end of our range of 7.2 to 10.5 per cent, reducing the overall estimate of detriment as compared with a figure based on the mid-point of 8.8 per cent;
  - (c) the analysis does not take into account the efficiency of the operators. To the extent that less efficient operators are making a lower ROCE, this inefficiency will not be reflected in our estimate of detriment; and
  - (d) during the recession, there may have been an adverse impact on the profitability of the relevant operators.
- 10.12 The figures shown in Table 10.1 are for the three largest private hospital operators combined, BMI, HCA and Spire. Together these firms account for 53 per cent of the privately-funded healthcare market.

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<sup>806</sup> These are: Bupa Cromwell Hospital, BMI, HCA, Nuffield, Ramsay, Spire and TLC.

TABLE 10.1 **Estimated detriment**

<i>Total detriment</i>	<i>All providers, £ million</i>		
	<i>FY09</i>	<i>FY10</i>	<i>FY11</i>
Detriment	155	175	174
% of private revenue	9.6	10.3	9.6

*Source:* CC analysis.

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10.13 In our view it is not practical to quantify the detriment arising from incentive schemes (paragraph 10.7 above) or from lack of information (paragraphs 10.7 and 10.8) although these features may increase the profitability of hospital operators and therefore be reflected to some extent in the estimates set out in paragraph 10.12.

## 11. Remedy measures that we are taking forward

### *Introduction*

- 11.1 In this section, we set out our assessment and consideration of the measures needed to remedy, mitigate or prevent the AECs and/or the resulting customer detriment that we have found. This section follows our consultation on our proposed package of remedies which we had set out in detail in our provisional decision on remedies, which was published on 16 January 2014. In reaching our final decision on the appropriate package of remedies, we have taken into consideration the views and the further evidence we have received from the parties to the investigation in their responses to our Remedies Notice, the provisional decision on remedies and our provisional findings.
- 11.2 In this section, we first set out the framework for consideration of the remedies before discussing each of the remedies included in the overall package in turn. For each remedy, we discuss its aims, the design of the remedy and its effectiveness and proportionality. Section 12 sets out our consideration of remedies that we are not pursuing, while Section 13 assesses the effectiveness and proportionality of the remedies package as a whole.

### *Framework for consideration of remedies*

- 11.3 Having identified a number of features that give rise to the AECs, we are required to decide the following additional questions:<sup>807</sup>
- (a) whether action should be taken by the CC for the purpose of remedying, mitigating or preventing the AEC concerned or any detrimental effect on customers so far as it has resulted, or may be expected to result, from the AEC;
  - (b) whether the CC should recommend the taking of action by others for the purpose outlined in (a); and
  - (c) in either case, if action should be taken, what action should be taken and what is to be remedied, mitigated or prevented.
- 11.4 A detrimental effect on customers includes such an effect on future customers and is defined as one taking the form of:<sup>808</sup>
- (a) higher prices, lower quality, or less choice of goods or services in any market in the UK (whether or not the market to which the feature or features concerned relate); or
  - (b) less innovation in relation to such goods and services.
- 11.5 In choosing appropriate remedial action, the CC has a statutory obligation to achieve as comprehensive a solution to the AEC and any detrimental effect on customers resulting there from as is reasonable and practicable.<sup>809</sup> The CC generally prefers to address the *causes* of the AEC directly. However, where this is not possible, or as an interim solution, the CC may introduce measures to mitigate the harm to customers created by the AEC.<sup>810</sup>

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<sup>807</sup> The Enterprise Act, section 134(4).

<sup>808</sup> Section 134(5).

<sup>809</sup> The Enterprise Act, section 134(6).

<sup>810</sup> CC3, *Guidelines for market investigations: Their role, procedures, assessment and remedies*, April 2013, [paragraph 333](#).

- 11.6 In practice, the CC may decide to take several discrete actions itself and/or make several discrete recommendations. This combination of measures is referred to as a package of remedies. In deciding what remedy or remedies are appropriate, the CC first looks for a remedy that will be effective in achieving its aims. The CC has made several general observations in its guidance about factors relevant to its consideration of effectiveness.<sup>811</sup> First, a remedy should be capable of effective implementation, monitoring and enforcement. The effectiveness of any remedy may be reduced if elaborate monitoring and compliance programmes are required. Second, the CC takes into account the time period over which a remedy is likely to have effect, including how quickly the remedy will take effect and the expected duration of the AEC that the remedy is designed to address. A third consideration is the way in which remedies interact with each other and with any other existing or expected regulation of the relevant market.
- 11.7 In considering the reasonableness of different remedy options, the CC has regard to their proportionality. In making an assessment of proportionality, the CC is guided by the following principles. A proportionate remedy is one that:<sup>812</sup>
- (a) is effective in achieving its legitimate aim;
  - (b) is no more onerous than needed to achieve its aim;
  - (c) is the least onerous if there is a choice between several effective measures; and
  - (d) does not produce disadvantages which are disproportionate to the aim.
- 11.8 In reaching a judgement about whether to implement a particular remedy, the CC considers its potential effects on those persons most likely to be affected by it, generally customers and the businesses subject to the remedies. The CC seeks to quantify the costs and benefits associated with a remedy where it is reasonably practicable to do so, taking into account any relevant customer benefits (RCBs) arising from the adverse feature or features of the market concerned. As set out in the Guidance,<sup>813</sup> RCBs are limited to benefits to relevant customers that take the form of:
- (a) lower prices, higher quality or greater choice of goods or services in any market in the UK (whether or not the market to which the feature(s) concerned relate); or
  - (b) greater innovation in relation to such goods or services.

## ***Divestiture remedy***

### ***Introduction***

- 11.9 We have found that the combination of weak competitive constraints in many local markets and high barriers to entry and expansion for private hospitals lead to higher prices for self-pay patients for certain types of treatments in these local markets and to higher prices for insured patients for treatment by HCA in central London. Our provisional findings also identified AECs in relation to the provision of private hospital services leading to higher prices to insured patients treated at BMI and Spire facilities outside central London. As set out in Section 10, we no longer find any AECs in this respect and we have reviewed the appropriateness of our remedies in light of this

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<sup>811</sup> CC3, paragraphs 334–341.

<sup>812</sup> CC3, paragraph 344.

<sup>813</sup> CC3, paragraphs 355–359.

change. We now consider that requiring the divestiture of any of the seven BMI hospitals identified in the provisional decision on remedies would not be a proportionate remedy for the AECs that we have found in relation to self-pay patients outside central London. We set out our full reasoning for this change of view in Section 12.

11.10 In this section, we first summarize the views of the parties in response to both the Remedies Notice and the provisional decision on remedies. In the light of parties' views, we set out our consideration of how the divestiture remedy addresses the AEC identified in central London and the factors that we have considered in designing the divestiture remedy, including our conclusions regarding the effectiveness of the remedy. Finally, we assess the likely costs and benefits of divestiture before concluding on the proportionality of the divestiture package.

11.11 We concluded that for the divestiture remedy to be both effective and proportionate, we will require HCA to divest either:

(a) the Wellington Hospital together with the Wellington Hospital Platinum Medical Centre (PMC); or

(b) the London Bridge Hospital and the Princess Grace Hospital.

### *Aim of remedy*

11.12 The remedy seeks to address the AECs arising from the structural features of weak competitive constraints and barriers to entry and expansion directly by introducing one or more additional competitors into the central London market or by strengthening existing competitors with a minor presence. By increasing choice for self-pay patients, insurers and international patients, divestiture should stimulate competition between operators on price, range and quality.

### *Views of parties*

11.13 In the following section, we summarize the parties' main arguments regarding the design, effectiveness and proportionality of the central London divestiture remedies set out in the provisional decision on remedies, ie the divestiture of the London Bridge and Princess Grace hospitals. Having set out a summary of these arguments, we set out our consideration of them in the sections that follow.

#### *Hospital operators*

- *HCA*

11.14 HCA put forward the view that the CC's proposed divestiture package, as set out in the provisional decision on remedies (ie London Bridge and Princess Grace), would be ineffective because:

(a) It was unlikely to lead to significant price reductions in central London if a new owner pursued a similar strategy to HCA since the substantial fixed costs incurred in operating its high-acuity hospitals would not permit a purchaser to replicate HCA's services and charge a lower price than HCA currently did. Without the synergies of the services offered by the HCA network, a new entrant would struggle to replicate the same level of efficiency and quality and may in some cases have to raise its prices.

- (b) There were significant risks that a new purchaser would not provide the same breadth of high-acuity, complex clinical service lines and therefore divestment would not create an effective competitor to HCA's remaining hospitals in the particular services in which HCA specialized.<sup>814</sup>
  - (c) The two hospitals proposed for divestiture each offered several services not provided elsewhere in the HCA network. Therefore, divestiture would not create a new competitor for certain of the treatments or specialized services currently provided by the two hospitals.
  - (d) The two hospitals were not stand-alone, autonomous businesses which could easily be separated without damaging HCA's hospital network benefits and divestment would therefore lead to increased costs.
  - (e) The CC could not be confident that the insurers would pass on any price benefits that did occur to patients—and indeed the evidence indicated that they would not. HCA put forward the view that the CC should conduct a detailed analysis of pass-through as the CC could not treat the PMIs as 'customers' as their incentives are not aligned with those of patients.<sup>815</sup>
- 11.15 HCA emphasized that the CC's findings in relation to central London were at variance with the OFT's assessment in 2000, when HCA acquired St Martin's Healthcare. The OFT cleared the merger unconditionally, concluding that the private healthcare market in London was highly competitive and that the relevant market included outer London hospitals. HCA stated that it had relied on this clearance to make substantial capital investments to develop and grow its business and that it was unfair and perverse for the CC to seek to reverse a competition authority's previous decision. HCA argued that the CC should explain how the market had evolved since 2000 and why the market was now significantly less competitive than in 2000. It stated that it was contrary to HCA's legitimate expectations and an abuse of process for the CC to seek to use a market investigation reference to overturn the OFT's earlier decision.<sup>816</sup>
- 11.16 HCA argued that the CC had carried out no 'proper' analysis of how divestiture would change PMI bargaining power to the extent that PMIs would achieve lower prices from either HCA or the divested hospitals.<sup>817</sup>
- 11.17 HCA also disagreed with what it described as the central rationale behind the divestment remedy, which was to reduce HCA's market share to below a specific threshold. It said that there was no EU or UK case law or guidance which supported a benchmark of 40 or 33 per cent as being in and of itself 'too high'. It noted that the OFT had cleared several mergers between parties that would have resulted in a market share in excess of 40 per cent, and said that HCA's share of supply was entirely consistent with a competitive market in which rival hospital operators competed on quality of care offered to patients.<sup>818</sup>
- 11.18 HCA said that the inclusion of outpatient facilities in any divestment remedy was 'inexplicable'. It said that the CC had not conducted any assessment of competition in the provision of outpatient facilities, and that there was strong competition among

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<sup>814</sup> [HCA response to provisional decision on remedies](#), paragraph 6.12.

<sup>815</sup> *ibid.*, paragraph 6.18.

<sup>816</sup> *ibid.*, paragraphs 2.6 & 4.59–4.65.

<sup>817</sup> *ibid.*, paragraph 6.13.

<sup>818</sup> *ibid.*, paragraphs 7.2–7.10.

outpatient facilities and very low barriers to entry or expansion, therefore their inclusion was not justified.<sup>819</sup>

11.19 HCA put forward the view that, as well as being ineffective, the proposed divestiture remedies were, in any event, disproportionate:

(a) HCA argued that the estimates of price benefits set out in the provisional decision on remedies were ‘grossly over-stated’ and that the CC could not rely on either the PCA or the IPA for the purposes of estimating the price benefits.<sup>820</sup>

(b) HCA stated that the CC’s analysis both understated the loss of economies of scale, failing properly to take into account evidence provided by HCA, and inappropriately dismissed that economies of scale were an RCB on the basis of ‘flawed’ insured pricing analysis.<sup>821</sup>

(c) HCA contended that the CC did not properly evaluate the likely loss of RCBs, in particular in relation to the effect on quality, innovation and patient care.

11.20 As regarded the loss of RCBs, HCA argued that divestiture would result in a reduction in the range of treatments available at both HCA’s divested and remaining hospitals, lower levels of investment in new equipment and clinical services in the future both within HCA’s remaining hospitals and in the divested hospitals, disruption to clinical pathways and knock-on impacts on patient care and continuity of treatment, and the loss of clinical know-how and expertise.<sup>822</sup> HCA said that, as a result, divestiture could have profoundly serious consequences for the health and well-being of patients. We set out HCA’s arguments on the loss of RCBs in the form of quality and range in detail in Appendix 11.1.

11.21 HCA identified several other negative effects arising from a divestiture process, including:

(a) A compulsory divestiture of assets which had taken many years to develop would be likely to have a chilling effect on investment in the UK. Potential investors, particularly from overseas, would be justifiably concerned that long-term investment in healthcare could be at the risk of similar treatment.

(b) The process of divestiture would have other destabilizing effects—on recruitment and retention of consultants and other clinical staff and on the readiness of overseas patients to come to London. This represented a substantial asset risk for the hospitals. HCA cited an example of how ownership uncertainty in the context of a US Federal Trade Commission investigation had caused a severe destabilizing effect on the hospital, including the large-scale defection of clinical staff.

11.22 HCA argued that the condition put forward by the CC that a purchaser of its facilities should not have any hospitals in close proximity to these businesses would apparently rule out any existing central London providers, which it claimed were the only UK-based providers which had a track record of operating high-acuity hospitals. It stated that this condition would both jeopardize its ability to obtain a fair market price

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<sup>819</sup> [HCA response to Remedies Notice](#), paragraph 6.91.

<sup>820</sup> [HCA response to provisional decision on remedies](#), paragraphs 6.37–6.45.

<sup>821</sup> *ibid*, paragraphs 6.46–6.50. HCA’s arguments in relation to the costs of divestitures and our consideration of them are set out in more detail in paragraphs 11.187–11.217 below.

<sup>822</sup> *ibid*, paragraphs 6.51–6.55.



for its assets and create a greater probability that the remedy would not secure the continuity of high-quality high-acuity services at these hospitals.<sup>823</sup>

11.23 HCA stated that the proposed time period of [X] months was too short and did not allow a reasonable amount of time for the business to: adequately market the facilities through a formal tender process, negotiate with potential purchasers, allow purchasers to conduct due diligence, negotiate and put in place transitional arrangements to ensure continuity of service and secure the relevant approvals (eg CQC approval) for a change in ownership. HCA argued that the proposed divestiture would be more complicated than the sale of Nuffield's nine hospitals to BMI due to the need to separate assets which were currently tightly integrated in a single geographic area and suggested that a period of between [X] and [X] months would be required. A shorter time period would adversely affect HCA's ability to secure a fair market value for the assets.<sup>824</sup>

11.24 Finally, HCA put forward the view that the possibility that, following a change of ownership, the insurers might not recognize the divested hospitals (or not recognize them on terms that allowed them to maintain the current level of quality and clinical services) posed a significant risk to the effectiveness of the divestiture remedy in creating new competitive constraints on HCA. HCA suggested that without PMI recognition the hospitals would not be viable, and that the CC's suggestion of rolling over recognition for 18 months implicitly recognized this but failed to address the longer-term issue.<sup>825</sup>

- *Other hospital groups*

11.25 Neither BMI nor Spire commented on our analysis of the central London market or the conclusions we drew from it. Spire, however, did indicate that the acquisition of hospitals in London could fit with its strategy, though a purchaser would require non-solicitation warranties from the vendor regarding key staff, in this case including consultants, in particular because a divested hospital in London would draw its consultants from the same NHS trust as one or more of the hospitals being retained by the seller.

11.26 [X]

11.27 Nuffield said that it agreed that divestiture was the appropriate remedy for central London,<sup>826</sup> and that the number of and particular hospitals proposed for divestiture were appropriate.

11.28 It said that HCA might encourage consultants to transfer their practice to a retained facility and that appropriate measures should be adopted to prevent this happening.

11.29 Nuffield considered that it would be helpful for assets to be sold individually, rather than bundled for sale; this would widen the range of prospective purchasers, as well as offering more choice to the consumers and consultants. It thought that the parties should be allowed six months to effect the sale of the properties being divested.

11.30 Circle said that it fully supported divestiture in central London and that it was an appropriate and proportionate remedy to the AEC. It said that, to ensure the effectiveness of the remedy, HCA should be prevented from running any more PPUs in

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<sup>823</sup> *ibid*, paragraphs 7.33–7.35.

<sup>824</sup> *ibid*, paragraphs 7.36–7.38.

<sup>825</sup> *ibid*, paragraphs 7.29–7.32.

<sup>826</sup> [Nuffield response to Remedies Notice](#), p4.

London for at least five years from the date of the divestment and that consultants currently practising at the hospitals to be divested should not be permitted to move their practice to a hospital retained by HCA for a period of two years post-divestment.<sup>827</sup> Circle considered that any sales should be made as soon as possible and completed within six months.

11.31 TLC suggested that any divestments in central London should be structured as a package to ensure that any new entrant could be an effective competitor. In its view, a divestment package for central London should include:

- (a) one or more hospitals currently offering a range of tertiary treatments on a sufficient, viable scale (ie London Bridge Hospital, the Wellington Hospital and the Harley Street Clinic);
- (b) oncology as a specialty within that range of tertiary treatments. The remedy should seek separate ownership of the assets and facilities which underpinned HCA's dominant position in oncology;
- (c) a break-up of HCA's 'super-dominant' position at a sub-specialty level; in oncology, the Wellington and LOC dominated in chemotherapy, the Harley Street Clinic and LOC held a dominant position in radiotherapy; and
- (d) a prohibition on hospitals with significant market power in central London from making further acquisitions of hospitals or relevant assets without prior approval from the CMA.

11.32 TLC considered that a suitably composed package would attract interest from several prospective purchasers, including from some not currently present in central London and from overseas buyers. In the past US organizations had been keen to enter the London market and there had been recent interest from the Far East and Middle East.<sup>828</sup> It considered that six months was a sufficiently long divestiture period.

#### *Insurers*

- *Bupa*

11.33 Bupa told us that the only way to remedy the AECs in central London was for HCA to divest a package of several hospitals and to reduce the influence that it claimed HCA had over primary care referrals. It said that divestments should be targeted at fostering competition at the specialism level, not just at an aggregate market share level.<sup>829</sup>

11.34 Bupa said that our proposed divestiture package (ie the London Bridge and Princess Grace hospitals) would be insufficient to address the AEC. It provided us with an analysis of its spend in central London broken down by HCA hospital and by clinical area of expenditure. We reproduce this in Figure 11.1.

11.35 Bupa said that this analysis showed that HCA's 'big three' hospitals in central London were the London Bridge and Wellington hospitals and the Harley Street Clinic. It said that these [redacted]. It said that, by contrast, the Princess Grace and Lister hospitals were general hospitals which were significantly smaller than the 'big three' with a [redacted]. It said that any divestment package that was limited to these facilities (ie the Princess

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<sup>827</sup> Circle response to Remedies Notice, Remedy 1.

<sup>828</sup> Summary of hearing with TLC, paragraph 7.

<sup>829</sup> Bupa response to Remedies Notice.

Grace and the Lister hospitals) would fail to address the AEC in central London. It said that this was especially the case in [REDACTED], which were [REDACTED].<sup>830</sup>

FIGURE 11.1

### HCA share of Bupa spend in central London, 2012

[REDACTED]

Source: Bupa.

- 11.36 Bupa considered several of the scenarios illustrated in its table. It said that in order to reduce effectively HCA's high market share in a range of specialties, divestments needed to be targeted at HCA's 'big three' facilities. It maintained that the divestment of the inpatient and outpatient facilities of the London Bridge and Wellington hospitals would most meaningfully reduce HCA's market share in the high-spend specialties of cardiology and orthopaedics to more competitive levels and would also reduce market share across a range of other, lower-spend, specialisms.<sup>831</sup> It also said that, [REDACTED], any divestiture package should include the [REDACTED] as an absolute minimum.<sup>832</sup>
- 11.37 In addition, Bupa submitted that HCA's Roodlane practice must be divested. It said that Roodlane was an important referral channel into the London Bridge Hospital. If HCA retained ownership of it, Roodlane would be in a position to weaken the new owner of the London Bridge Hospital by redirecting patients away. Bupa said that Roodlane and London Bridge Hospital should be sold to different buyers.<sup>833</sup>
- 11.38 Finally, Bupa said that the divestment remedy would need to be accompanied by a number of behavioural remedies in order to ensure its effectiveness. These included a ban on consultant incentives, to prevent HCA poaching key consultants away from the facilities that it divested, restrictions on HCA's expansion through PPU JVs and [REDACTED].<sup>834</sup>
- 11.39 In Bupa's view, some potential purchasers should not be considered suitable, for example one of the existing large hospital groups (BMI, Nuffield, Ramsay, Spire). There was also some concern that, if these groups participated in the divestment process, they would gain sight of confidential pricing data. Bupa highlighted that if an insurer purchased a divested hospital (ie if there was any vertical integration), other insurers should have access to that facility on fair and reasonable terms.<sup>835</sup>
- 11.40 Bupa considered that the timetable for divestment did not need to be longer than six months. If that proved unsuccessful, a divestment trustee should be appointed with a mandate to complete the deal within three months.
- AXA PPP
- 11.41 AXA PPP agreed with the CC that the most effective remedy that would address the AEC in central London would be to require HCA to divest a substantial part of its portfolio. AXA PPP said that it negotiated across HCA's portfolio of hospitals but that

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<sup>830</sup> *ibid*, p38.

<sup>831</sup> *ibid*, paragraph 4.93.

<sup>832</sup> *ibid*, paragraph 4.89.

<sup>833</sup> *ibid*, paragraph 4.94.

<sup>834</sup> *ibid*, paragraph 4.100.

<sup>835</sup> *ibid*, paragraphs 4.55–4.61.

there was no opportunity for it to encourage hospitals in the HCA group to compete with each other and HCA had no incentive to allow this.

- 11.42 AXA PPP said that no remedy other than divestiture was likely to be effective. It considered whether requiring HCA to negotiate prices for each of its hospitals separately would address the AEC, but concluded that it would not do so.<sup>836</sup> It said that if AXA PPP chose to exclude certain HCA hospitals from its network, this would be likely to result in significantly higher prices at hospitals that it chose to include.<sup>837</sup>
- 11.43 AXA PPP said that the greatest competition would arise in London if all the major ‘must-have’ hospitals were owned by different groups. However, bearing in mind the principle of proportionality, it was not proposing this but instead a divestiture that would give rise to three competing groups with a credible portfolio. These would comprise TLC, HCA and the new owner. AXA PPP said that the portfolio of each group would need to include:
- (a) a significant flagship in central London;
  - (b) Harley Street provision;
  - (c) coverage for a full range of specialisms; high-acuity cover; and
  - (d) a full cancer service including radiotherapy.<sup>838</sup>
- 11.44 AXA PPP identified the three flagship London hospitals as TLC, the Wellington and the London Bridge, on which basis HCA should be required to divest either the Wellington or the London Bridge Hospital, neither of which TLC should be permitted to acquire.
- 11.45 AXA PPP said that in terms of reputation, a Harley Street location was synonymous with top quality and was a trusted brand.<sup>839</sup> It said that HCA owned two of the largest facilities in the Harley Street area, in addition to running the PPU at UCH which it said was nearby.<sup>840</sup> AXA PPP said that a Harley Street presence could be provided and specialism gaps filled by combining divestment of a flagship hospital together with other HCA facilities. It proposed that the Wellington or the London Bridge hospitals be divested along with the Harley Street Clinic or the Princess Grace Hospital and that TLC should not be permitted to acquire either the Harley Street Clinic or the Princess Grace Hospital.<sup>841</sup> This arrangement would therefore result in three competing groups operating facilities in the vicinity of Harley Street.
- 11.46 In addition, AXA PPP said that it did not support the ownership by hospital groups of primary care facilities. It acknowledged that the CC had not found that these vertical relationships had influenced referral rates but felt that HCA could set up arrangements whereby its primary care providers made substantial referrals to their retained facilities. It therefore proposed that HCA be required to divest, as a minimum, either Roodlane or Blossoms Inn.<sup>842</sup>
- 11.47 AXA PPP said that LOC comprised a leading team of 50 oncologists who were responsible for the care pathways of a significant number of patients who received

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<sup>836</sup> AXA PPP response to provisional findings and Remedies Notice, paragraph 2.4.

<sup>837</sup> *ibid*, paragraph 2.5.

<sup>838</sup> *ibid*, paragraph 2.10.

<sup>839</sup> *ibid*, paragraph 2.21.

<sup>840</sup> *ibid*, paragraph 2.20.

<sup>841</sup> *ibid*, paragraph 2.25.

<sup>842</sup> *ibid*, paragraphs 2.29–2.32.

their treatment in London, and that just under half of AXA PPP's patients received treatment provided by an LOC consultant.<sup>843</sup>

11.48 AXA PPP said that it considered that such an organization should be independent of any features that might influence its referral patterns and proposed that HCA also be required to divest LOC.

11.49 AXA PPP said that PPUs had the capacity to offer significant competition to private hospitals but that they would not do so if they were managed by the same hospital operators. It therefore proposed that HCA, and any new owner of London Bridge Hospital, be required to divest its contract to run the Guy's and St Thomas' NHS Foundation Trust PPU.<sup>844</sup>

- *Aviva*

11.50 Aviva said that it thought a divestiture remedy was likely to have the greatest impact in central London given the area's importance to patients, the high prices that HCA charged to PMIs and the fact that HCA owned a cluster of eight hospitals in this area with a share of supply of above 45 per cent of inpatient admissions.

11.51 However, Aviva raised concerns regarding the risk that divestiture of, for example, the London Bridge Hospital could result in the transfer of market power from one operator to another.<sup>845</sup> The new owner of this hospital, for example, could continue to charge the same prices as HCA, initially at least. It said that it was therefore important that the CC adopted other remedies, such as checks on tying and bundling, as part of its package.<sup>846</sup>

11.52 Aviva said that it thought the divestiture should be designed so as to result in three operators each controlling one of the major London acute hospitals. It said that this could be achieved if HCA was required to divest the London Bridge and either the Wellington or Princess Grace hospitals. It said that if this could be achieved, it could then offer corporate clients, for example, a 'tiered proposition' with a choice of prices and service levels which it was not possible to offer currently.

11.53 Aviva said that in order to enable the new owner of the divested HCA hospitals to place a competitive constraint on HCA, the divestiture package should include some of HCA's primary care, diagnostic centres and consulting rooms. Aviva highlighted that HCA owned approximately 95 per cent of all consultation rooms, outpatient and diagnostic centres in the City of London (EC1 postcode) and that it also owned additional primary care facilities and three occupational health facilities (Roodlane, Blossoms and Galen) which were all based in this area.

11.54 Finally, Aviva told us that it believed that any lower prices achieved as the result of the CC's remedies (both structural and behavioural) would be passed on to customers in lower premiums.

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<sup>843</sup> *ibid*, paragraph 2.33.

<sup>844</sup> *ibid*, paragraphs 2.44–2.46.

<sup>845</sup> Aviva said that BMI should be prevented from acquiring London Bridge Hospital and TLC from acquiring the Princess Grace Hospital.

<sup>846</sup> [Aviva response to Remedies Notice](#), p4.

- *PruHealth*

11.55 PruHealth said that it was ambivalent as to whether HCA's divestment of one or more of its private hospitals would benefit the market. It said that many of HCA's hospitals operated in an area of duopoly with another independent hospital within easy drive-time, for example the Princess Grace Hospital and TLC. It said that the exception was the London Bridge Hospital, which would retain solus market power irrespective of its ownership.<sup>847</sup>

### *Design issues and effectiveness assessment*

11.56 We have set out in paragraphs 11.3 to 11.8 the factors that the CC takes into account in choosing appropriate remedial action, including the effectiveness of the remedy and its reasonableness and/or proportionality. As an introduction to our consideration of divestiture remedies, we set out some general considerations regarding divestiture, as well as the specific factors that we have taken into account in this investigation.

#### *General considerations regarding divestiture remedy options*

11.57 A divestiture remedy generally seeks to address an AEC directly by changing the structure of the market either by introducing a new competitor into the market or by strengthening an existing competitor with a minor presence in the market in order to allow it to compete more effectively.

11.58 Where a structural measure, such as divestiture, is appropriate, it is likely to have advantages over behavioural measures as it will address at source the lack of rivalry resulting from structural features of a market and will generally not require detailed monitoring beyond the completion of the disposal of the business or assets in question. In addition, divestiture remedies can generally be expected to address the AEC identified (and the customer detriment arising) in a timely manner.

- *Alternative effective remedy options*

11.59 We considered whether there were any other, potentially less intrusive, remedies that would be effective in addressing the AECs identified. As we explain in more detail in Section 12, we do not believe that there are any behavioural remedies that will be effective in addressing the AECs by constraining the market power of HCA in central London, either with respect to self-pay patients or in its negotiations with the insurers. Similarly, we have considered but rejected the remedy of a price control (see Section 12), which we thought would be only partially effective in addressing the AECs arising from weak competitive constraints.<sup>848</sup> In addition, we thought a price control would create potentially damaging distortions to the market, particularly with regard to quality and range, as well as being very costly to implement, monitor and enforce.<sup>849</sup>

11.60 We considered whether our remedy requiring new agreements between private hospital operators and NHS trusts for the operation of NHS PPUs to be reviewed by the CMA would be effective in increasing competitive constraints by encouraging new entry in central London. We reasoned that, in the longer run, this remedy was likely

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<sup>847</sup> [PruHealth response to Remedies Notice](#), Issues for comment 1, paragraph (a).

<sup>848</sup> We thought that while a price control may be effective in reducing prices, it would be unlikely to encourage competition on quality or range in the market.

<sup>849</sup> See Section 12 for our detailed consideration of a price control remedy.

to facilitate new entry but we concluded that the time frame for such entry, whether such entry took place in central London (or elsewhere in the UK),<sup>850</sup> as well as the likely scale of any entry, was uncertain, such that this remedy could not be relied upon to ensure the emergence of an effective competitive constraint on HCA in central London in the foreseeable future. Furthermore, we observed that currently many central London PPUs focus on one or a small number of specialties<sup>851</sup> and therefore entry via this route was unlikely to provide an effective competitive constraint on HCA as it may not provide a sufficiently broad range of specialties.

11.61 Finally, we considered whether our information remedies would address the weak competitive constraints. We reasoned that, in the longer run, they were likely to increase the constraints on hospitals and consultants (both within and outside central London) by enabling both patients and insurers to make informed choices between providers on the basis of their value proposition (ie their price-quality offering). In particular, we thought that the greater availability of quality information might encourage patients to travel further where they perceived a quality benefit from doing so, effectively increasing the size of local markets and therefore the number of hospitals contesting those markets. However, we did not think that this customer response would be sufficiently strong within the foreseeable future to address substantially the AECs identified in central London. We concluded, therefore, that divestiture remedies were the only effective and reasonable solution to the AECs identified in central London.

- *Designing an effective divestiture remedy*

11.62 To be effective, a divestiture should involve the disposal of an appropriate divestiture package to a suitable purchaser through an effective divestiture process. An effective divestiture remedy is therefore based on three critical elements:

- (a) *Appropriate divestiture package.* In general, a divestiture remedy is more likely to be effective if the divestiture package comprises a unit that is able to compete effectively on a stand-alone basis rather than a collection of assets. We normally seek to identify the smallest operating unit or units whose divestiture will address the AEC.
- (b) *Suitable purchasers.* Suitable purchasers should be independent of the divesting party or parties and any related party, and should have appropriate expertise, commitment and financial resources to operate and develop the divested business as an effective competitor. In addition, acquisition of a divestiture package by a suitable purchaser should not itself create further competition or regulatory concerns.
- (c) *Effective divestiture process.* An effective divestiture process should ensure that divestiture of an appropriate divestiture package to a suitable purchaser takes place within a reasonable time period. It should also ensure that the business to be divested does not deteriorate prior to its sale. An effective divestiture process will also be designed in such a way as to facilitate the vendor receiving a fair market value for the divested assets.

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<sup>850</sup> We note that this remedy applies nationwide and not only in central London.

<sup>851</sup> For example, the UCLH PPU operated by HCA focuses on haematology, while the Guy's and St Thomas' PPU (also operated by HCA) will have a focus on oncology when it opens. The Royal Marsden PPU is focused on cancer treatments, Moorfield's PPU focuses on ophthalmology and the Great Ormond Street PPU focuses on paediatrics.

*Specific considerations regarding divestiture of HCA hospitals in central London*

11.63 HCA argued that our divestiture remedies would be ineffective in reducing prices in central London since its hospitals already faced sufficient competitive constraints. We set out our detailed reasoning and findings in respect of the link between high prices and weak competitive constraints in central London in Section 6. In this section, we first summarize our rationale for concluding that our divestiture remedy would exert downward pressure on prices in central London, before considering each of the three critical elements: appropriate divestiture package, suitable purchasers and effective divestiture process, in relation to our divestiture remedy in central London.

- *Effectiveness*

11.64 As set out in Section 5, we defined a separate central London market as the geographic area enclosed by the North and South Circular Roads. We concluded that it is a feature of the central London market that there are weak competitive constraints acting on HCA as well as barriers to entry and expansion. We reasoned that divestments could address the AECs arising from these weak competitive constraints and barriers to entry and expansion directly by introducing one or more new competitors or strengthening one or more existing, smaller competitors in the market.

11.65 We considered the extent to which our proposed divestitures would affect prices.<sup>852</sup> We noted that the results of our price-concentration analysis—which estimated that self-pay prices decline by just over 3.4 per cent for every 20 percentage point reduction in weighted average local market share—show that divestitures which reduce local market shares should have a direct effect on the prices charged to self-pay patients.<sup>853</sup> We were unable to conduct a price-concentration-type analysis for insured patients as prices are generally negotiated between private hospital operators and PMIs nationally rather than on a hospital by hospital basis. However, we analysed the prices charged by the private hospital operators to insurers ('insured price analysis'). We found that over the relevant period, HCA charged [X] per cent more, on average, to insurers than TLC, its nearest competitor in central London, with this difference increasing between 2007 and 2011 and reaching [X] per cent by the end of the period.<sup>854</sup> We concluded that this insured price analysis supported the finding that HCA's market power in central London enabled it to negotiate higher prices with insurers. On the basis of these two types of pricing analysis, we reasoned that the divestiture of one or more of HCA's hospitals in central London would serve to reduce the prices it charged to both self-pay patients and insurers. We have set out our detailed analysis of the likely impact of divestiture on the prices charged to self-pay, insured and international patients in Appendix 11.2.

11.66 We did not identify an AEC in terms of low(er) quality or range arising from either of these structural features, or any other features, of the market. However, in paragraphs 11.223 to 11.225, we discuss the potential impact of our divestiture remedy on the quality and range of private healthcare services provided in central London.

- *The appropriate divestiture package*

11.67 In this section, we set out our consideration of the design of a divestiture package in central London to meet our criteria for an effective and proportionate remedy. In

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<sup>852</sup> We consider HCA's criticisms of the reliability of the PCA and IPA separately. See Appendices 6.9 and 6.12 respectively.

<sup>853</sup> See Appendix 6.9.

<sup>854</sup> See Appendix 6.12.



order to achieve a proportionate solution, the CC will seek to identify the smallest such package (or packages) that is likely to result in the emergence of a viable competitor and satisfactorily address the AEC.<sup>855</sup>

11.68 In order to assess the effectiveness of a divestiture package, we reviewed the conclusions that we had come to regarding the functioning of the private healthcare market in the UK and in central London, in particular. We thought that the following factors were important:

- (a) We concluded that the appropriate product market definition was that of a medical specialty. We noted that while patients had very little ability to substitute between treatments (even within a specialty), hospitals had some ability to substitute across treatments within an existing specialty. However, we observed that supply-side substitution appeared to be greater for more routine treatments than for the more complex, ‘high-acuity’ or ‘tertiary’ treatments in which HCA has a particularly strong position.<sup>856</sup>
- (b) We noted that the insurers and hospital operators negotiate a price across a ‘bundle’ of treatments, with hospital operators seeking to increase treatment prices for the remaining services in response to insurers’ attempts to reduce the number of treatments for which they recognize a given hospital operator.<sup>857</sup>
- (c) We reasoned that the combination of a specialty-level product market, and prices which are negotiated jointly across a full range of services, suggested that a strong market position in one or a small number of specialties would allow a private hospital operator to exert market power. This conclusion is consistent with the views of the insurers in relation to the central London divestiture remedy, as set out in paragraphs 11.33 to 11.54, which highlighted the importance of having the ability to substitute away from HCA across the full range of specialties in order to generate a competitive constraint. However, we also thought that we should take account of the use of ‘networks’ of providers by the insurers in order to assess the non-HCA offering available to customers. Post-divestiture, the combination of all non-HCA hospitals should be able to offer customers an alternative across all medical specialties. Therefore, we reasoned that either the strengthening of an existing competitor, or the introduction of a single additional competitor into the central London market, would be sufficient to provide an effective competitive constraint on HCA provided that the divestiture package was of a sufficient scale to facilitate the switching by insurers away from the remaining HCA hospitals.
- (d) We found that central London hospitals were only weakly constrained by those outside central London, with around 95 per cent of patients resident in central London choosing to travel to a hospital in central London, with only 5 per cent travelling to a hospital in Greater London, whilst, for patients resident in Greater London, the balance is very different: around 54 per cent of patients chose to travel to a Greater London hospital, and around 46 per cent chose to travel to a central London hospital.<sup>858</sup> The insurers told us that the location of hospitals within central London could confer a competitive advantage, with AXA PPP highlighting the importance of a Harley Street location in terms of brand and reputation for a hospital.

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<sup>855</sup> CC3, Annex B, paragraph 10. Following discussion with the parties, the CC may modify the scope of the proposed divestiture package provided that the parties can demonstrate that the modified package addresses the AEC.

<sup>856</sup> See Section 5.

<sup>857</sup> See Appendix 6.11, paragraphs 219–230.

<sup>858</sup> See Appendix 6.10.

- (e) We found that high barriers to entry and expansion in central London, including those arising from limited site availability and difficulties obtaining planning permission, were a feature of the market giving rise to an AEC.

11.69 As we set out in paragraph 11.57, a divestiture remedy generally seeks to address an AEC directly by changing the structure of the market either by introducing a new competitor into the market or by strengthening an existing competitor in the market in order to allow it to compete more effectively. In the first instance, we noted that a divestiture remedy was necessary in order to increase the level of competitive constraint on HCA, as high barriers made either entry or expansion, on a sufficient scale to achieve such a competitive constraint, unlikely in the foreseeable future.

11.70 On the basis of our understanding of the private healthcare market, as set out in paragraph 11.68, we took into account a number of factors in assessing the effectiveness of various potential divestiture packages, including:

- (a) the range of medical services offered by HCA's hospitals;
- (b) the size and scale of HCA's hospitals in terms of its admissions, revenues and capacity including capacity constraints; and
- (c) the customers served by HCA's hospitals, including their geographic location and whether they are self-pay, insured or overseas patients.

- *Range of medical services*

11.71 We found that HCA had a strong market share (measured on the basis of admissions) across a number of specialties. We observed that it had a particular strength in complex specialties, such as cardiology and neurology, as well as in the four largest specialties by admissions: oncology, trauma and orthopaedics, gastroenterology, obstetrics and gynaecology. HCA has a share of over 40 per cent in 10 of 17 specialties considered, and a share of over 60 per cent in seven of these specialties.

TABLE 11.1 Central London shares of supply by specialty, 2011

	Share of total admissions by specialty							per cent
	HCA	TLC	BMI*	Bupa Cromwell	St John & St Elizabeth	Other private hospitals†	PPUs‡	Specialty admissions as proportion of all admissions
Oncology	[X]	[X]	[X]	[X]	[X]	[X]	27.4	14.3
Trauma and orthopaedics	[X]	[X]	[X]	[X]	[X]	[X]	1.9	11.8
Gastroenterology	[X]	[X]	[X]	[X]	[X]	[X]	1.7	10.6
Obstetrics & gynaecology	[X]	[X]	[X]	[X]	[X]	[X]	12.1	7.6
General surgery	[X]	[X]	[X]	[X]	[X]	[X]	7.9	7.3
Cardiology	[X]	[X]	[X]	[X]	[X]	[X]	20.0	5.0
Plastic surgery	[X]	[X]	[X]	[X]	[X]	[X]	3.2	4.9
Urology	[X]	[X]	[X]	[X]	[X]	[X]	4.7	4.3
Ophthalmology	[X]	[X]	[X]	[X]	[X]	[X]	3.7	4.0
General medicine	[X]	[X]	[X]	[X]	[X]	[X]	18.7	2.4
Oral & maxillofacial surgery	[X]	[X]	[X]	[X]	[X]	[X]	1.5	1.6
Anaesthetics	[X]	[X]	[X]	[X]	[X]	[X]	1.9	1.5
Otolaryngology	[X]	[X]	[X]	[X]	[X]	[X]	8.5	1.4
Neurology	[X]	[X]	[X]	[X]	[X]	[X]	28.6	1.2
Clinical radiology	[X]	[X]	[X]	[X]	[X]	[X]	4.0	0.5
Dermatology	[X]	[X]	[X]	[X]	[X]	[X]	15.2	0.3
Rheumatology	[X]	[X]	[X]	[X]	[X]	[X]	4.5	0.1

Source: CC analysis.

\*Data is not available for one BMI hospital for obstetrics and gynaecology, trauma and orthopaedics and urology. This hospital accounts for less than 1 per cent of total admissions in central London. Data is not available for one BMI hospital for ophthalmology and two BMI hospitals for dermatology. The missing data for each BMI hospital is estimated to be less than 0.5 per cent of its total admissions in central London.

†Other private hospitals include Aspen and King Edward VII's Hospital Sister Agnes. Data for Aspen is not available for ophthalmology and rheumatology. The missing data for Aspen is estimated to be less than 0.5 per cent of its total admissions in central London.

‡Data on admissions is not available for some PPUs for some specialties. The missing data for the six PPUs combined is estimated to be around 3 per cent of all central London admissions.

Note: N/A = not available. Total admission figures include inpatient and day-case admissions.

11.72 We reasoned that, if divested, a more specialized hospital might place less of a competitive constraint on the remaining HCA hospitals than one offering a broad range of services given HCA's high market share across a large number of medical specialties. In particular, we were concerned that a divestiture remedy might be ineffective if it did not provide the insurers with alternative provision to HCA across the most important specialisms. On the other hand, we recognized that it would be possible for a purchaser to adapt a hospital's service offering to incorporate new treatments and specialisms, for example by attracting consultants in different specialisms, hiring new specialist staff, or acquiring new equipment, but that this process would be likely to take time, and it would also require that the divestiture package contained sufficient spare capacity to facilitate such an expansion of the service offering. Our guidance requires us to consider how quickly a remedy is likely to take effect.<sup>859</sup>

11.73 Therefore, in assessing the effectiveness of different possible divestiture packages, we have taken into account the extent to which they would release shares of supply within key specialisms to competitors to enable PMIs in particular to offer policies without HCA. We have also considered the ability of and speed with which a purchaser or purchasers of the divestiture package could extend the service offering of the divested hospital(s) to compete in these key specialisms. See paragraphs 11.140 to 11.143 for our consideration of these issues.

<sup>859</sup> CC3, paragraph 337.

11.74 We examined the mix of the 17 mainstream specialisms offered by HCA's hospitals in central London.<sup>860</sup> We show the results of this analysis in Figures 11.2 and 11.3.

FIGURE 11.2

### HCA hospital's admissions by main specialisms, 2011\*



Source: HCA.

\*The graph shows admissions (inpatient and day-case) for the 17 mainstream specialties plus neurosurgery and cardiothoracic surgery only. It does not show admissions at these facilities in other specialisms. The admission figures for the Wellington Hospital in this graph include the PMC, a day-case and outpatient facility that is operated as an annex to the Wellington Hospital.

FIGURE 11.3

### HCA hospital revenues by main specialisms, 2011\*



Source: HCA.

\*The figures in this graph for each HCA hospital include the revenues generated by associated day-case and outpatient facilities, including those which do not admit patients.

11.75 We observed that four of HCA's facilities in central London offered a broad range of specialisms: the Wellington, London Bridge, Princess Grace and, to a lesser extent, the Lister, with all of these hospitals admitting patients for trauma and orthopaedics, gastroenterology, urology, general medicine, anaesthetics and general surgery. We noted that the Harley Street Clinic had a strong focus on cardiology and oncology, two of HCA's key strengths, but that its offering in other specialisms, including trauma and orthopaedics, gastroenterology and obstetrics and gynaecology, was relatively limited. The Portland was heavily focused on obstetrics and gynaecology, while LOC and the Harley Street Cancer Centre were entirely focused on oncology.

11.76 We observed that London Bridge Hospital and the Wellington offered the broadest range of specialisms, including cardiology and neurosurgery. In addition, London Bridge Hospital admitted patients for oncology treatment, while the Wellington had a particular strength in neurology and neurosurgery.<sup>861</sup> In contrast, the Lister and Princess Grace did not admit patients for treatment in cardiology or oncology. We noted, however, that these figures were based on admissions and revenues as of 2011. Since 2011, HCA has developed its oncology offering at the Wellington Hospital and its associated day-case and outpatient facility, the PMC.<sup>862</sup> The PMC now has a ten-bed chemotherapy unit, while the Wellington Hospital has a dedicated inpatient oncology unit.<sup>863</sup> HCA has also developed specialist breast and prostate cancer services at the Princess Grace Hospital.<sup>864</sup>

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<sup>860</sup> We note that neurology and neurosurgery have been separated out, as have cardiology and cardiothoracic surgery.

<sup>861</sup> While these specialisms are relatively small in terms of admissions, they generate a disproportionate quantity of revenue.

<sup>862</sup> The PMC is a dedicated outpatient and day-case facility, located on Lodge Road (near the Wellington Hospital). It comprises seven floors, with 50 consulting rooms, 4 day surgery operating theatres, a 12-bed day surgery unit, which also has a minor procedure suite with 10 reclining chairs, a 10-bed day case chemotherapy unit operated in partnership with LOC and a diagnostic imaging centre.

<sup>863</sup> [www.theplatinummedicalcentre.com/News-Detail.aspx?NewsID=15](http://www.theplatinummedicalcentre.com/News-Detail.aspx?NewsID=15); [www.theplatinummedicalcentre.com/LOC.aspx](http://www.theplatinummedicalcentre.com/LOC.aspx); <http://thewellingtonhospital.com/Our-Services-Sector.aspx?sid=86>; [www.theplatinummedicalcentre.com/Our-Services-Oncology.aspx](http://www.theplatinummedicalcentre.com/Our-Services-Oncology.aspx).

<sup>864</sup> [www.theprincessgracehospital.com/hospital-services/services/breast-care/](http://www.theprincessgracehospital.com/hospital-services/services/breast-care/); [www.theprincessgracehospital.com/hospital-services/services/urology/](http://www.theprincessgracehospital.com/hospital-services/services/urology/).

○ *Scale/size of the hospital*

11.77 The next factor that we considered was the size or scale of HCA's hospitals. We considered HCA's current market share in terms of admissions, share of revenue and share of capacity to understand the impact that the various potential divestiture packages would have on shares of supply in the market held by HCA and its competitors. We observed that HCA had a [40–50] per cent share of total admissions in central London in 2011, with the Wellington Hospital accounting for [X] per cent,<sup>865</sup> the London Bridge [X] per cent, the Princess Grace [X] per cent, and the Lister, [X] per cent. Table 11.2 sets out the impact on HCA's share of admissions that would result from divesting various combinations of its generalist hospital facilities.

TABLE 11.2 **Divestment options expressed as share of admissions, 2011**

<i>Divested hospitals</i>	<i>per cent</i>	
	<i>Share</i>	<i>HCA share</i>
Lister	[X]	[X]
Princess Grace	[X]	[X]
Wellington	[X]	[X]
Wellington + Lister	[X]	[X]
London Bridge	[X]	[X]
London Bridge + Lister	[X]	[X]
Wellington + Princess Grace	[X]	[X]
Wellington + Princess Grace + Lister	[X]	[X]
London Bridge + Princess Grace	[X]	[X]
London Bridge + Princess Grace + Lister	[X]	[X]
London Bridge + Wellington	[X]	[X]
All four hospitals	[X]	[X]

Source: HCA, CC analysis.

11.78 In 2011, HCA had a [50–60] per cent share of the total revenue for central London, with the Wellington accounting for approximately [X] per cent, the London Bridge [X] per cent, the Princess Grace [X] per cent, and the Lister [X] per cent. Table 11.3 sets out the impact on HCA's share of revenues that would result from divesting various combinations of its generalist hospital facilities.

TABLE 11.3 **Divestment options expressed as revenue share, 2011\***

<i>Hospitals divested</i>	<i>per cent</i>	
	<i>Hospital share</i>	<i>Resulting HCA share</i>
Princess Grace	[X]	[X]
Lister	[X]	[X]
London Bridge	[X]	[X]
Wellington	[X]	[X]
London Bridge + Princess Grace	[X]	[X]
Wellington + Princess Grace	[X]	[X]
Wellington + London Bridge	[X]	[X]
All four hospitals	[X]	[X]

Source: HCA, CC analysis.

\*All revenue shares exclude HCA's day-case and outpatient facilities.

<sup>865</sup> This figure excludes admissions to the PMC.

- 11.79 Next, we examined shares of capacity. There are several potential measures of capacity, including overnight beds, operating theatres, consulting rooms and ITU beds. We note first that the interpretation and the collection of capacity data has presented certain problems. For example, particular indicators of capacity may be more relevant to some hospitals than others. The operating theatre capacity of a hospital or clinic which specializes in chemotherapy or radiotherapy, for example, may not give a reliable indication of its capacity for treating patients with cancer. The number of overnight beds at a hospital may not be a reliable indicator of capacity as different specialisms or different patient types may have different hospital stay profiles. For example, stay times for overseas patients are on average longer than for UK patients. Consequently a hospital treating a high proportion of overseas patients will need more bed capacity for any given number of admissions than a hospital treating mainly UK patients. Further, we encountered some practical difficulties in collecting PPU capacity data since resources such as theatres are also used for NHS patients. With those caveats, we reproduce<sup>866</sup> below a table showing capacity measurements using four measures.<sup>867</sup>
- 11.80 We observed that, using these measures, HCA had a share of capacity in central London of between 46.5 per cent (overnight bed capacity, including the PPUs) and around [%] per cent (ITU beds, excluding PPU provision). These shares of capacity were relatively similar to the share of admissions held by HCA, which was [40–50] per cent of total admissions (across all care types), rising to [over 60] per cent for tertiary inpatient admissions.<sup>868</sup> We note that the capacity figures exclude outpatient and day-case facilities for all operators. In the case of HCA, some of these outpatient and day-case facilities are integral to the operation of its full-service hospitals, such as the PMC at the Wellington Hospital.<sup>869</sup>

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<sup>866</sup> From Appendix 6.10.

<sup>867</sup> We have used data from the Laing and Buisson's Healthcare Market review 2011/12 on the number of NHS dedicated beds for PPUs; however, we did not find similar data for the other three measures of capacity, ie theatres, consulting rooms and critical care beds level 3. In relation to these, therefore, our analysis of capacity shares focuses on private hospitals only.

<sup>868</sup> See Appendix 6.10, Table 10.

<sup>869</sup> [www.theplatinummedicalcentre.com/News-Detail.aspx?NewsID=15](http://www.theplatinummedicalcentre.com/News-Detail.aspx?NewsID=15).

TABLE 11.4 Capacity in private hospitals providing inpatient services in central London, 2011

	Overnight beds		Theatres		Consulting rooms		Critical care beds level 3	
	Number	%	Number	%	Number	%	Number	%
<i>Aspen</i>								
Highgate Hospital	28	1.8	3	3.8	12	2.8	0	0
<i>BMI</i>								
Blackheath	69	4.3	4	5	21	4.9	0	0
Fitzroy Square	16	1.0	1	1.3	7	1.6	0	0
London Independent	58	3.6	4	5	10	2.3	6	7.1
Weymouth	10	0.6	4	5	0	0.0	0	0
Total BMI	153	9.6	13	16.3	38	8.8	6	7.1
<i>HCA*</i>								
Harley Street Clinic	104	6.5	4	5	51	11.9	20	23.5
Lister Hospital	74	4.6	4	5	31	7.2	2	2.4
London Bridge Hospital	111	7.0	7	8.8	56	13.0	8	9.4
Portland Hospital	87	5.5	4	5	39	9.1	3	3.5
Princess Grace Hospital	114	7.2	8	10	38	8.8	4	4.7
Wellington Hospital	226	14.2	11	13.8	20	4.7	20	23.5
NHS ventures UCLH	24	1.5						
Total HCA	740	46.5	38	47.6	235	54.7	57	67
St John & St Elizabeth	49	3.1	5	6.3	36	8.4	0	0
King Edward VII's Sister Agnes	60	3.8	3	3.8	6	1.4	4	4.7
The Bupa Cromwell	118	7.4	5	6.3	29	6.7	7	8.2
TLC	170	10.7	13	16.3	74	17.2	11	12.9
<b>Total private hospitals</b>	<b>1,318</b>	<b>82.8</b>	<b>80</b>		<b>430</b>		<b>85</b>	
Guy's & St Thomas' Trust	43	2.7	N/A		N/A		N/A	
Imperial College Healthcare NHS trust	106	6.7	N/A		N/A		N/A	
King's College Hospital NHS Foundation Trust	21	1.3	N/A		N/A		N/A	
Royal Brompton and Harefield NHS Foundation Trust	31	1.9	N/A		N/A		N/A	
Royal Free London NHS Foundation Trust	52	3.3	N/A		N/A		N/A	
The Royal Marsden NHS Foundation Trust	21	1.3	N/A		N/A		N/A	
<b>Total PPUs</b>	<b>274</b>	<b>17.2</b>						

Source: CC analysis.

\*Data on HCA London Oncology Centre (LOC) is already included in our analysis for three capacity measures; namely theatres, overnight beds and critical beds. These three capacity measures belong to the various HCA hospitals and, therefore, are taken into account in the statistics for other HCA hospitals included in our analysis. However, data on LOC consulting rooms are not included because they are not in a hospital with inpatient capacity. We note that if we include LOC data, HCA's share of consulting rooms increases by 1.1 per cent (54.7 to 55.8). The 4 theatres and 50 outpatient consulting rooms at the PMC are not included in this table as the facility does not offer inpatient treatments. However, we note that the PMC is operated in conjunction with the Wellington Hospital and was developed in order to facilitate the expansion of the Wellington Hospital: [www.theplatinummedicalcentre.com/News-Detail.aspx?NewsID=15](http://www.theplatinummedicalcentre.com/News-Detail.aspx?NewsID=15).

11.81 HCA's share of revenue was higher than its share of admissions in 2011, which we thought was likely to be due, at least in part, to its high share of tertiary inpatient admissions ([60–70] per cent) and, in part, to charging higher prices than its competitors. In most cases, the shares of admissions and shares of capacity held by HCA's hospitals were relatively similar.

11.82 However, we did observe differences between share of capacity and share of admissions/revenue at the Wellington Hospital. The Wellington Hospital's share of beds is greater than its share of admissions or revenue. It has a 14.2 per cent share of overnight beds and a 23.5 per cent share of critical care beds but an 8.1 per cent share of admissions and a 12.5 per cent share of revenue. The reverse is true for both the London Bridge and Princess Grace Hospitals whose shares of admissions and revenue are somewhat greater than their share of beds. We thought that these differences were likely to be due to the different profile of patients at the Wellington, which treats a larger proportion of international patients than the London Bridge and

Princess Grace hospitals. (See Table 11.6 for a breakdown of insured, international and self-pay revenues for each of HCA's four general hospitals.)

- 11.83 In terms of capacity, the Wellington is the largest single hospital, even excluding the PMC, which has an additional four theatres and 46 to 50 consulting rooms but is not included in the table above as it does not have inpatient facilities. The Wellington (including the PMC) has approximately twice the beds and theatre capacity of either the London Bridge or the Princess Grace. The London Bridge and the Princess Grace have similar levels of capacity, while the Lister is the smallest of the four.
- 11.84 The second largest operator in terms of capacity is TLC, which accounts for 11 per cent of overnight beds, 16 per cent of theatres, 17 per cent of consulting rooms, and 13 per cent of critical care level 3 beds. On all four measures of capacity, HCA is around three to four times larger than its next closest rival, TLC.
- 11.85 We next undertook the same analysis that we had using admissions and revenue data, examining the shares of capacity that would be made available by different divestiture packages and the result these various options would have on HCA's remaining share (see Table 11.5). Here, we have considered capacity in terms of the number of overnight beds only, as we have PPU data for this measure. However, in our assessment below, we have taken into account shares of capacity across all measures.

TABLE 11.5 Divestment options expressed as shares of overnight bed capacity, 2011

<i>Hospitals divested</i>	<i>per cent</i>	
	<i>Hospital share</i>	<i>Resulting HCA share</i>
Lister	4.65	42.35
London Bridge	6.97	40.03
Princess Grace	7.16	39.84
London Bridge + Lister	11.62	35.38
London Bridge+Princess Grace	14.13	32.87
Wellington	14.20	32.80
Wellington+London Bridge	21.17	25.83
Wellington+Princess Grace	21.36	25.64
All four hospitals	32.98	14.02

Source: CC analysis.

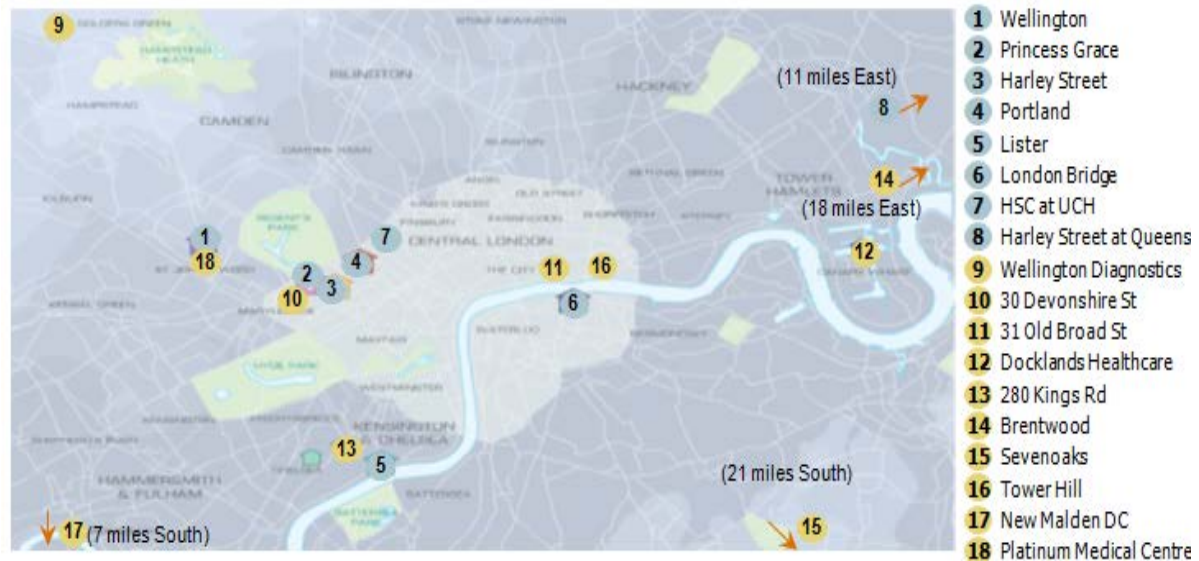
#### ○ *Customers served*

- 11.86 We considered that if the customer bases of the four hospitals differed markedly, this could have a bearing on the design of our divestiture package. We began by examining whether the hospitals' location had an influence on the types of patient who used the hospital, for example on the basis of where they lived or worked or the treatment that they were receiving.
- 11.87 We show in Figure 11.4 where HCA's healthcare facilities, including diagnostic and outpatient centres, in London are located, including the four general hospitals that we have identified.



FIGURE 11.4

### HCA's London facilities



Source: HCA.

11.88 The Wellington Hospital, together with the PMC, are located in St John's Wood, north of Regent's Park; the Princess Grace is located in the Harley Street area of the West End; the London Bridge is located on the south bank of the Thames in Southwark; and the Lister is in Chelsea. We considered that the location of the London Bridge Hospital made it attractive to corporate clients located in the City, and that the Princess Grace would benefit from the reputation effect of being located in the Harley Street area.

11.89 There is an HCA outpatient centre located close by the Princess Grace Hospital (and Harley Street Clinic), at 30 Devonshire Street.<sup>870</sup> HCA operates a number of other outpatient centres, including some located in the City, Golders Green, Docklands and Sevenoaks in Kent. The Lister hospital is located close to an HCA outpatient facility on the Kings Road in Chelsea.

11.90 The Princess Grace Hospital is located close to three other HCA facilities in the vicinity of Harley Street (LOC, the Harley Street Clinic and the Portland hospital) and to major independent hospitals (TLC and King Edward VII's). It is also located reasonably close to University College Hospital with which HCA operates PPU facilities.<sup>871</sup> The London Bridge Hospital is located close to Guy's Hospital with which HCA is jointly developing a PPU to be situated within the new Guy's and St Thomas' Trust Cancer Centre which is due to open in 2016. The Wellington Hospital is located very close to St John and St Elizabeth's Hospital and reasonably close to the NHS St Mary's Paddington and Royal Free hospitals.

11.91 The catchment areas of the four hospitals are shown in Figure 11.5.

<sup>870</sup> The Princess Grace Hospital lists this as one of its five outpatient sites. None of these is listed by the Harley St Clinic as outpatient facilities in its Patient Guide, p6.

<sup>871</sup> Harley Street at UCH.

FIGURE 11.5

### Catchment areas of the London Bridge, Wellington, Princess Grace and Lister hospitals

[REDACTED]

Source: HCA.

11.92 We noted first that all four hospitals treat patients from across London. However, the area from which the London Bridge Hospital draws patients was [REDACTED] than that of the Princess Grace, Lister and Wellington hospitals, [REDACTED]. The catchment area of the London Bridge Hospital also extends [REDACTED].

11.93 We did not consider that this data in itself was particularly helpful in differentiating the customer bases of the four hospitals since the hospitals concerned did not draw patients from discrete, local areas. Central London hospitals are located more closely together than they tend to be elsewhere in the UK. Consequently, the overlap between their catchment areas, including those of the four HCA hospitals, is considerable, as can be seen from Figure 11.5.

11.94 We looked next at the revenue that these hospitals generated from different customer types: insured, self-pay and overseas. The proportion of each hospital's revenue earned from these categories of customer is shown in Table 11.6.

TABLE 11.6 Revenue share by payer, 2011

	<i>per cent</i>			
	<i>PMI</i>	<i>Self-pay</i>	<i>NHS</i>	<i>Overseas</i>
London Bridge	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Princess Grace	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Wellington	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]
Lister	[REDACTED]	[REDACTED]	[REDACTED]	[REDACTED]

Source: HCA.

11.95 We considered that this data did help differentiate the four hospitals. [REDACTED], as is shown in Table 11.7.

TABLE 11.7 PMI revenue, 2011

	<i>£m</i>
London Bridge	[REDACTED]
Princess Grace	[REDACTED]
Wellington	[REDACTED]
Lister	[REDACTED]

Source: HCA.

11.96 We were unable separately to identify corporate and individual PMI patient revenues. However, in our research among employers offering private health cover as part of their employee benefits schemes,<sup>872</sup> City-based financial and professional services firms mentioned the London Bridge Hospital as important because of its location.

<sup>872</sup> See Appendix 2.1.

- *An effective divestiture package—our assessment*

11.97 A key risk to the effectiveness of a divestiture remedy is that the scope of the divestiture package may be too constrained or not appropriately configured to attract suitable purchasers and may not allow a purchaser to operate as an effective competitor in the market.<sup>873</sup>

- *Customers served*

11.98 We considered AXA PPP's argument that it would be important for a competitor to HCA to include a Harley Street hospital in its portfolio on the basis of the status and reputation associated with that location. We also took into account the importance of the London Bridge Hospital to corporate clients. However, while we considered that certain locations may confer competitive advantages, we concluded that this factor was not relevant to the effectiveness of a divestiture package.

11.99 We considered that the effectiveness of a divestiture package should be assessed in the context of the total competitive constraint on HCA's remaining hospitals in central London. We reasoned that as there were already a number of competitor hospitals in the Harley Street area, including TLC and King Edward VII's, it was not necessary to specify that another hospital in this area should be divested as insurers and self-pay patients already had access to non-HCA providers in this area. In the case of London Bridge, we reasoned that this was the only private hospital in this location and, therefore, divesting it to another operator would not address any competitive advantage derived from its location but would only transfer that advantage to the purchaser. Our review of the catchment areas of HCA's hospitals demonstrated a high level of geographical overlap, which supported our conclusion that any of HCA's hospitals could compete effectively for patients across the central London market and beyond. Therefore, we determined that location within central London was not a relevant factor to take into account in designing an effective divestiture remedy.

11.100 In terms of the customer base of each hospital, we considered that this could change following a divestiture as HCA and its existing and new competitors sought to compete across all customer segments. For example, if HCA were to divest the Wellington Hospital, which currently has a strong focus on international patients, we reasoned that a purchaser would be likely to seek to attract a greater number of insured patients to the hospital in order to grow its revenues.

- *Range of specialisms*

11.101 We concluded that divesting a general hospital, ie one offering treatments across a broad range of specialisms, would be more effective in addressing the AECs than would divesting a more specialized one given HCA's high market shares across a broad range of specialisms. We identified four HCA hospitals that could be characterized as general hospitals in that they offered services and generated revenue across a wide range of specialisms. These were the Wellington and the London Bridge hospitals, both large, and the smaller Princess Grace and Lister hospitals.

11.102 We received no evidence to indicate that our analysis of specialisms offered was flawed or that our characterization of the Wellington, London Bridge, Princess Grace and Lister as general hospitals was incorrect. However, it was argued by [X] AXA PPP that while these hospitals did not specialize in any one particular condition,

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<sup>873</sup> In our guidelines, this risk is referred to as 'composition risk': CC3, [Annex B](#), paragraph 6.

method of treatment or type of patient, they did exhibit differing strengths in specialisms.

11.103 We examine the mix of specialisms provided by the hospitals concerned in detail as part of our consideration of which hospital(s) would need to be divested in order to provide a rival with sufficient and appropriate facilities and resources to allow it to provide an effective competitive constraint on HCA's remaining hospitals (in conjunction with other central London PHPs) across a broad range of specialisms.

○ *Hospital size/scale*

11.104 We considered that the size of a facility was important in two respects. First, we thought it was important that any hospital divested was sufficiently large in order to be able to operate at an efficient scale and therefore to compete effectively on the range and quality of services it provides. Second, we thought that the divestiture package would need to create sufficient incremental, non-HCA supply to facilitate switching by insurers (and thereby exert an effective competitive constraint on HCA).

11.105 We examined the size of HCA's competitor facilities, and took into account evidence provided by BMI and Spire. [X] Spire told us that in order to compete effectively in the London market, [X]. We observed that a number of HCA's competitors, including King Edward VII, St John and St Elizabeth, and BMI (London Independent and Blackheath) operated hospitals with between three and five theatres and between 50 and 70 overnight beds. We reasoned that this indicated that it was possible to operate efficiently at this scale in this market and, on this basis, we concluded that any of HCA's general hospitals would be of a sufficient scale to operate effectively on a stand-alone basis in the central London market.<sup>874</sup>

11.106 We considered that an individual hospital was the smallest unit that could be expected to operate effectively on a stand-alone basis.<sup>875</sup> We examined HCA's argument that the inclusion of outpatient facilities in any divestment package was 'inexplicable' as the CC had not assessed competition in the provision of outpatient services and there was strong competition among outpatient facilities and low barriers to entry and expansion. We did not agree that this meant that day-case or outpatient facilities should not be included within the divestiture package. We reasoned that, in order for a purchaser of a hospital to compete effectively with HCA from the point of purchase, it would need to acquire a business comprising all the key facilities of a private full-service hospital, including, inter alia, operating theatres, inpatient and day-case bedrooms, consulting rooms and diagnostic facilities. We considered that there was a significant risk that, in the absence of this requirement, a purchaser might acquire a business that needed to be substantially expanded or reconfigured before it could operate effectively and that this would reduce the effectiveness of the divestiture package. Where there were separate day-case and/or outpatient facilities used by the divested assets, we considered that they should be included in the divestiture package to the extent that they were required either for the effective operation of the divested hospital(s) or for the overall effectiveness of the divestiture remedy.<sup>876</sup> This is considered further in paragraphs 11.133 to 11.136.

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<sup>874</sup> We set out our consideration of HCA's arguments regarding the network effects that arise from its co-ownership of hospitals in Appendix 11.1.

<sup>875</sup> In accordance with our guidance: CC3, [Annex B](#), paragraph 9.

<sup>876</sup> HCA owns a mixture of freehold and leasehold buildings. Where the hospital property was also owned by HCA, we considered that this should form part of the divestiture package. In general, where a hospital building was leased from a third party, we thought that it would be appropriate to require the lease to be assigned to any purchaser of the business.

11.107 We examined HCA's argument that revenue shares of supply could be misleading as prices might reflect quality or the level of acuity of treatments and that the appropriate measure to use was share of capacity. We reasoned that the key factor in determining the effectiveness of the divestiture remedy would be ensuring that non-HCA hospitals are able to absorb insurers' volumes currently treated at HCA hospitals across the full range of specialties. In the absence of product and geographic differentiation, we consider rivals' spare capacity to be the most appropriate measure to consider, but we note that we have not been able to obtain robust data on spare capacity. The CC guidelines suggest that the CC uses several indicative measures so as to understand fully how a market is operating. We have therefore considered shares based on revenues, admissions and capacity. Given that we did not find evidence of material quality differences between HCA and some of its close competitors in central London, we note that our finding that HCA charges higher prices may itself be an indication of the lack of spare capacity at HCA's close competitors, and that this is captured in our shares of revenue.

11.108 In considering the appropriate scale of the divestiture in order to create an effective competitive constraint, our primary concern was to identify the least onerous divestiture package which would create sufficient non-HCA supply to facilitate switching by insurers. We took into account the views of the parties on the scale of the divestiture required. AXA PPP had proposed that either the Wellington or the London Bridge hospital should be divested together with the Harley Street Clinic, thus enabling a new owner to operate what it described as a 'flagship' hospital as well as a facility in the Harley Street area. It told us that TLC should be prevented from buying either such that PMIs would have a choice between three operators. Aviva similarly favoured divestment on a scale that would permit the creation of a third central London operator. Bupa told us that divesting a hospital the size of the Princess Grace or the Lister would not address the AEC and submitted that both the London Bridge and Wellington hospitals should be divested. It said that at the very least the divestiture package should include the London Bridge Hospital. Nuffield told us that it would be necessary for HCA to divest two of its hospitals in order to offer PMIs more choice.

11.109 We considered whether our guidelines could help us determine or be informative as to the scale of divestment that would be necessary to enable a rival or rivals acquiring the divestiture package to constrain HCA competitively. Our merger guidelines state that, in undifferentiated markets, shares of less than 40 per cent have not generally given the OFT cause for concern over unilateral effects.<sup>877</sup> We noted that DG Comp has, albeit in the context of market dominance cases, tended to regard it as unlikely for a firm with a market share of less than 40 per cent to be dominant.<sup>878</sup> However, the markets we are considering are not undifferentiated, ie they have a significant degree of product differentiation and market shares may therefore overstate the closeness of competition. In the CC's investigation of the proposed joint venture between Anglo American PLC and Lafarge SA,<sup>879</sup> in the context of the SLC assessment the CC used a 33 per cent threshold due to the degree of product and geographic differentiation. On this basis, we considered that a 40 per cent threshold could be too high in the circumstances of a differentiated market though we also considered that which assets were to be divested would have a bearing on the appropriate size and configuration of the divestiture package.

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<sup>877</sup> CC2, paragraph 5.3.5.

<sup>878</sup> See paragraph 14 of Guidance on the Commission's enforcement priorities in applying Article 82 of the EC Treaty to abusive exclusionary conduct by dominant undertakings, 2009: [http://eur-lex.europa.eu/legal-content/EN/ALL/?sessionId=MRLTT1TZpshYQQ32JLJz2IJ3xmpyDFk5xZgrXphgkZD4DXL3wDNc!-636218035?uri=CELEX:52009XC0224\(01\)](http://eur-lex.europa.eu/legal-content/EN/ALL/?sessionId=MRLTT1TZpshYQQ32JLJz2IJ3xmpyDFk5xZgrXphgkZD4DXL3wDNc!-636218035?uri=CELEX:52009XC0224(01)).

<sup>879</sup> <http://www.competition-commission.org.uk/our-work/directory-of-all-inquiries/anglo-american-lafarge>

11.110 However, we did not consider that absolute and aggregate share of supply was the only factor that we should include in our overall appreciation. We considered that our assessment should be more broadly based, encompassing HCA's aggregate share of supply relative to that of its competitors and its share of supply relative to competitors within specialisms as well as the views of the PMIs on what scale of divestiture would enable an acquirer to provide them with sufficient choice to constrain HCA competitively.

11.111 We next examined each of the potential divestiture packages, comprising HCA's general full-service hospitals in turn, taking into account both the shares of supply held by the hospital and the range of specialisms offered.

- *Assessment of divestiture options*

11.112 First, we considered whether divesting the Lister hospital would be effective in addressing the AECs. The Lister is the smallest of the HCA facilities that we characterized as general hospitals and it has a share of admissions which is lower than either TLC or the Bupa Cromwell. Divesting the Lister would create an additional competitor with a share of [X] overnight bed capacity of around 5 per cent and a share of critical care bed capacity of 2.4 per cent. If it were divested, HCA would retain in excess of 60 per cent of ITU beds in central London, which we considered to be important for competing in high-acuity treatments. We reasoned that creating an additional competitor that was smaller than Bupa Cromwell (in terms of beds) and which only increased the number of non-HCA critical care beds in central London by 2.4 per cent was unlikely to result in an effective competitive constraint on HCA's remaining facilities.

11.113 We were concerned that, although a general hospital, the Lister also had a more limited presence in some of the key specialties where HCA's market share was particularly high, including cardiology, clinical radiology, oncology and anaesthetics. While the hospital appears to have sufficient spare capacity (in terms of beds and theatres) to widen its service offering and increase the volume of patients treated, we considered that expanding into several new, complex specialisms, as well as extending the range of high-acuity treatments offered, which would be required in order to provide an effective competitive constraint on HCA's remaining hospitals, would be likely to take a number of years. Such an expansion would require the Lister to increase the number of critical care beds very substantially and attract a large number of consultants across these specialisms to practise at the hospital. In addition, we did not believe that a hospital of the scale of the Lister would be large enough to accommodate such a broad-based expansion of service offering and volumes. On this basis, we concluded that divestment of the Lister alone would not create an additional rival which together with existing competitors would effectively constrain HCA.

11.114 We next considered whether divesting the Princess Grace Hospital on its own would (in association with existing competitors) create an effective competitive constraint on HCA. The Princess Grace has a [5–10] per cent share of admissions and a [5–10] per cent share of revenue, which makes it a similar size to the Bupa Cromwell. We reasoned that creating an additional competitor of this size, and which only increased the number of non-HCA critical care beds in London by just under 5 per cent, was unlikely to result in an effective competitive constraint on HCA's remaining facilities.



11.115 We noted that, while the Princess Grace offered a broad range of specialties, its effectiveness as a competitive constraint<sup>880</sup> on HCA might also be limited by the lack of cardiology and oncology work undertaken at the facility, although we noted the hospital's service offering in breast and prostate cancer. We considered that these specialisms could be developed by a purchaser, noting that the Princess Grace also appears to have a reasonable level of spare capacity, but that this would take time and might, in the case of cardiology, require larger critical care facilities than the Princess Grace currently has. As in the case of the Lister, we did not consider that a hospital of the size of the Princess Grace would have sufficient capacity to create an effective competitive constraint on HCA across the broad range of medical specialisms, even in combination with HCA's other central London competitors. We thought that it would represent only a limited alternative to HCA for the PMIs, particularly the larger ones. We concluded that divesting the Princess Grace Hospital on its own would not address the AECs in central London.

11.116 We next considered whether divesting the Princess Grace Hospital together with the Lister would address the AECs. While the combination of these two hospitals would create significant additional non-HCA capacity in terms of overnight beds and operating theatres, it would not increase significantly the level of non-HCA critical care bed capacity in the market (7 per cent of total capacity), nor would it address the gaps in service offering identified in paragraphs 11.113 to 11.115. Therefore, as in the case of each hospital individually, we reasoned that, in order to provide an effective competitive constraint on HCA, a purchaser or purchasers of the divested hospitals would need to both expand the critical care facilities substantially in order to accommodate a larger volume of high-acuity treatments, and expand the service offering of the hospitals. In the absence of such changes, the divestiture package would not serve to facilitate switching by the insurers for higher-acuity treatments, and would not therefore create a rival or rivals that were able to constrain HCA. We considered that, while such expansion of services and facilities might be accommodated by these two hospitals in combination, it would be likely to take an extended period of time to reconfigure hospital buildings to include critical care and oncology facilities and to attract new consultants across a range of specialisms. Therefore, we did not consider that an entity of this size and range of specialisms and facilities would have the necessary scale, even in combination with the other non-HCA competitors in central London, to provide an effective competitive constraint on HCA in a timely manner.

11.117 We then considered whether divesting the London Bridge, HCA's largest single hospital in admission terms and second largest in revenue terms, would (in combination with the existing competitors) provide an effective competitive constraint on HCA. The London Bridge has a share of supply in admissions of less than TLC's and offers insurers a significantly smaller capacity, with 111 overnight beds compared with TLC's 170, and seven operating theatres, compared with TLC's 13. We did not consider that an additional competitor which was smaller than TLC would represent a significant increase in non-HCA capacity in the market. In addition, we were concerned that following the divestiture of the London Bridge Hospital, HCA would retain in excess of 57 per cent of the critical care beds in central London, which we reasoned may make it difficult for the insurers to switch all their volumes, including higher-acuity volumes, to an alternative provider.

11.118 We thought that the London Bridge would be likely to provide an effective constraint in terms of the range of specialisms that it offered, which included cardiology, oncology, gastroenterology and obstetrics and gynaecology, as well as general medicine

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<sup>880</sup> In conjunction with HCA's other competitors in central London.

and anaesthetics. On the other hand, we noted that the London Bridge is currently capacity constrained,<sup>881</sup> which we considered would limit the ability of a purchaser to expand existing service lines or develop new service lines. On balance, therefore, we concluded that, if the London Bridge were divested, additional capacity would need to be divested with it to ensure the effectiveness of the remedy.

- 11.119 Next, we considered whether divesting the London Bridge Hospital together with either the Lister or Princess Grace would be sufficient in scale to remedy the AECs. Divestment of the Lister together with the London Bridge would allow a rival to create a business larger than TLC's but leave HCA with more than one-third of admissions and 40 per cent of total revenues. We thought that this divestiture might be sufficient in terms of its size/scale to provide an effective competitive constraint on HCA (in combination with other non-HCA providers in London). However, we were concerned that the limited service offering and critical care capacity of the Lister, particularly in certain specialisms where HCA has a high market share, such as oncology, anaesthetics and cardiology, would limit effectiveness as a constraint on HCA, at least in the short term.
- 11.120 Divestment of the Princess Grace together with the London Bridge would, potentially, enable a rival or rivals to acquire hospitals together larger than TLC, though still less than half the size of the remainder of HCA. We noted that, as well as having more overnight bed, critical care bed and theatre capacity than the Lister, the Princess Grace also had a larger share of admissions in key specialties, such as trauma and orthopaedics, gastroenterology, anaesthetics and urology. In addition, we reasoned that the Princess Grace's strengths in breast and prostate cancer could provide a platform for the hospital to develop a competitive oncology offering relatively rapidly. On balance, therefore, we considered that the combination of the London Bridge and the Princess Grace would be likely to provide an effective constraint on HCA, whereas the combination of the London Bridge and the Lister would not.
- 11.121 Finally, we considered whether divesting the Wellington, the second largest HCA hospital in admissions terms and the largest in revenue terms, would be sufficient to enable a competitor to constrain HCA. Divesting the Wellington would leave HCA with a share of admissions of [40–45] per cent and a share of revenue of [40–45] per cent, which we considered to be relatively high in the context of a highly differentiated market. However, the Wellington Hospital's share of capacity in central London, as measured by overnight beds, is 14 per cent, while its share of critical care beds is 23.5 per cent, which is significantly more than that of either the Lister and Princess Grace or the London Bridge and the Princess Grace hospitals combined. We reasoned that these beds are important for providing high-acuity treatments, in which HCA has a particularly high share of admissions ([60–70] per cent).
- 11.122 In contrast, we observed that the Wellington Hospital had a relatively small number of consulting rooms (see Table 11.4), which would be likely to limit its effectiveness as a stand-alone hospital. However, we noted that consulting rooms were largely provided for consultants practising at the Wellington in the PMC, which has an additional 50 consulting rooms and four theatres, as well as in the Wellington Diagnostics and Outpatients Centre in Golders Green, which has a further 16 consulting rooms. While on an adjacent site, we considered that the PMC capacity formed an integral part of the current operations of the Wellington Hospital and should be taken into account when considering the likely effectiveness of the Wellington as a competitive constraint. Although operated in association with the Wellington Hospital, we did not

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<sup>881</sup> See paragraph 6.83. We consider the impact of the additional space that HCA is planning to open in the Shard in paragraphs 11.128 to 11.131.



conclude that the Wellington Diagnostics and Outpatients Centre in Golders Green was essential to the effective functioning of the hospital (see paragraph 11.135 for further discussion of this). Once the PMC is taken into account, we reasoned that the Wellington had sufficient scale to provide an effective constraint on the remaining HCA hospitals (in combination with other non-HCA operators in central London) if it were divested.<sup>882</sup>

11.123 We also took into account the wide range of specialisms currently offered by the Wellington, including cardiology, neurology and neurosurgery, obstetrics and gynaecology, gastroenterology, trauma and orthopaedics, general medicine and anaesthetics. Furthermore, as explained in paragraph 11.76, since 2011 the Wellington has developed its oncology offering with a ten-bed chemotherapy unit and an on-site oncology pharmacy at the PMC, as well as a ten-bed inpatient oncology unit.<sup>883</sup>

11.124 We considered that the Wellington's broad range of specialisms, including those areas in which HCA currently has a particularly high market share, indicated that it would compete with HCA's remaining hospitals across the large majority of privately-provided acute healthcare treatments. We reasoned that its substantial capacity, in terms of overnight and intensive care beds, would allow it to compete aggressively for additional patients. We thought that the limited number of consulting rooms at the Wellington Hospital (20 consulting rooms for a 226-bed hospital), which HCA has addressed via its expansion into the PMC, meant that to operate effectively, the Wellington would need to be sold together with the PMC, at a minimum.<sup>884</sup> This condition would also be required to ensure that the Wellington was able to compete effectively in oncology given that the PMC contains the chemotherapy unit for the hospital. We concluded, therefore, that the Wellington would be likely to provide an effective competitive constraint on the remaining HCA hospitals if it were to be divested in combination with the PMC.

○ *Conclusions on divestitures*

11.125 In assessing the likely effectiveness of the various potential divestiture packages, our aim has been to create a new rival to HCA in central London which, together with existing competitors, would effectively constrain HCA. We have sought to identify the smallest effective package to create a new rival to HCA. We have taken into account a number of factors in our overall appreciation of the likely effectiveness of the various potential divestiture packages, including the views of the parties and the various types of guidance and 'safe harbour' thresholds applied by us and by other competition authorities in mergers and cases of market dominance. In particular, we have considered our understanding of the functioning of the private healthcare market in central London, the evidence on shares of supply held by HCA's and its competitors' hospitals in central London and examination of various possible divestiture portfolios and the sufficiency of the competitive constraint that they would enable.

11.126 We concluded that a divestiture of either the Wellington Hospital together with the PMC, or the London Bridge Hospital together with the Princess Grace Hospital, would be of a sufficient scale and provide a sufficiently broad range of specialisms to

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<sup>882</sup> We note that the PMC relieved the capacity constraints that had previously existed for the Wellington Hospital. See: [www.theplatinummedicalcentre.com/News-Detail.aspx?NewsID=15](http://www.theplatinummedicalcentre.com/News-Detail.aspx?NewsID=15).

<sup>883</sup> [www.theplatinummedicalcentre.com/Uploads/Brochures/Platinum%20Medical%20Centre,%20London.pdf](http://www.theplatinummedicalcentre.com/Uploads/Brochures/Platinum%20Medical%20Centre,%20London.pdf); [www.theplatinummedicalcentre.com/News-Detail.aspx?NewsID=15](http://www.theplatinummedicalcentre.com/News-Detail.aspx?NewsID=15); <http://thewellingtonhospital.com/Our-Services-Cancer.aspx>; <http://thewellingtonhospital.com/Our-Services-Sector.aspx?sid=86>.

<sup>884</sup> HCA's [website](#) highlights that the PMC provides outpatient facilities for patients of the Wellington Hospital.

remedy the AECs. We considered that a divestiture on a larger scale, say of the Wellington together with the London Bridge hospitals or the Wellington and the Princess Grace, would be able to address the AECs comprehensively but that a smaller, less intrusive remedy would be effective. We did not consider that a divestment of the London Bridge together with the Lister would remedy the AECs given the smaller scale of the Lister compared with the Princess Grace and the more limited range of services it provides.

11.127 We next considered whether it was possible to identify any facility other than the Princess Grace or Lister hospitals which, if combined with the London Bridge, would still provide a sufficient package to enable an acquirer to constrain HCA.

11.128 We were aware from HCA's submissions and from our own research that London Bridge Hospital had been facing capacity constraints for some time and had been seeking additional premises nearby. We knew that HCA had leased three floors of the Shard building in Southwark for medical use. We considered whether, thus expanded, the London Bridge Hospital would constitute an operation of sufficient scale to enable a rival to constrain HCA.

11.129 The additional space which HCA has acquired in the Shard has planning consent that would permit inpatient treatment, although HCA intends to use it, initially at least, for diagnostic and outpatient treatments, as well as office accommodation for administrative staff.<sup>885</sup> It was not clear to us whether this space could be used to house, for example, operating theatre facilities, given their technical requirements including air handling. Nonetheless, we noted that it might be possible to free suitable space for operating theatres in the main hospital building by transferring other activities to the new building or by using space in the PPU it is developing with GST.

11.130 However, we noted that the space acquired in the Shard by HCA (approximately [X] square metres) is significantly less than that available at the Princess Grace Hospital (approximately [X] square metres). We reasoned that, for the reconfiguration of the London Bridge Hospital (using the Shard) to create an effective competitive constraint on HCA's remaining hospitals, it would need to result in a substantial increase in the number of overnight beds, operating theatres and critical care beds at the combined facility. We thought that it was possible that the additional space provided by the Shard would permit such a reconfiguration. However, we also considered it likely that such a reconfiguration would take a significant period of time, particularly for a new owner which would first have to obtain its own planning permission for medical use for the space in the Shard,<sup>886</sup> before then developing consulting rooms in that space and, only then, converting consulting room space in the London Bridge Hospital to additional theatres and beds (both critical care and overnight). We considered that this delay in obtaining additional (usable) capacity would compromise the effectiveness of the divestiture remedy.

11.131 Similarly, to the extent that the reconfiguration of space at London Bridge and the Shard would entail transferring activities to the PPU at the GST, this would require HCA to also divest the PPU contract to the new owner of the London Bridge. This in itself would add to the intrusiveness and complexity of the remedy and result in delay in implementing it since the GST PPU is not scheduled to open until late 2016. We therefore concluded that divesting the London Bridge Hospital on its own, even

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<sup>885</sup> Letter from CEO of London Bridge Hospital to Southwark Council, dated 24 September 2013.

<sup>886</sup> HCA's planning permission for the space which it has leased in the Shard is specific to HCA. As a result, a new owner of the London Bridge Hospital would need to go through the planning process again in order to develop the Shard for medical use. The [planning decision](#) of Southwark Council states that 'Since this is a personal planning permission, any other healthcare/medical facilities operators wishing to occupy these levels would not be permitted'.

taking account of its forthcoming acquisition of additional space in the Shard, would not enable the acquirer to constrain HCA competitively.

11.132 We therefore concluded that HCA should be required to divest:

- (a) the Wellington Hospital together with the PMC; or
- (b) the London Bridge Hospital together with the Princess Grace Hospital.

○ *Other assets*

11.133 We considered whether any additional assets, other than those discussed above, would be required by an acquirer in order to ensure the efficient operation of the divested facilities and therefore for the effectiveness of the remedy. In particular, we considered whether any additional consulting rooms or outpatient diagnostic and treatment facilities should be included. We noted that we had not found a barrier to entry in relation to these facilities but we reasoned that it was likely that it would take a purchaser some time to locate and develop suitable facilities in proximity to its hospitals<sup>887</sup> and, therefore, a sufficient proportion of consulting rooms and diagnostic facilities would be required at the time of acquisition to ensure effective competition.

11.134 We noted that the consulting facilities at 30 Devonshire Street and 47 Nottingham Place are related to the Princess Grace Hospital.<sup>888</sup> We considered, therefore, whether these should be included as part of the Princess Grace in order to ensure that the hospital was able to operate effectively. Our analysis of the ratio of consulting rooms to overnight beds indicated that the Princess Grace had a relatively low ratio when compared with certain other HCA hospitals, such as the Harley Street Clinic or the London Bridge. However, it had a similar ratio to the Wellington (taking the facilities at the PMC into account) and a higher ratio than the Bupa Cromwell and King Edward VII. We considered, therefore, that it was not necessary to specify that the outpatient facilities at 30 Devonshire Street or 47 Nottingham Place should be included in the divestiture package. We concluded that a purchaser could expand the number of consulting rooms over time if it thought that it could grow revenues by doing so.

11.135 We considered whether the Diagnostics and Outpatients Centre in Golders Green should be included in the Wellington Hospital and PMC divestiture package. While we noted that with around 70 consulting rooms, the Wellington Hospital had a lower ratio of consulting rooms to overnight beds than other HCA hospitals, we thought that it was not necessary for the effective operation of the hospital (and therefore, the effectiveness of the remedy) that the additional 16 consulting rooms and the other diagnostic facilities contained in the Golders Green centre be divested alongside the Wellington Hospital and the PMC. We concluded that with 70 consulting rooms, a purchaser could operate effectively from the point of acquisition and that it could expand the number of consulting rooms over time if it thought that it could grow revenues by doing so.

11.136 Finally, we considered whether it would be necessary to specify that, if the London Bridge Hospital were divested, HCA should divest the space it has recently acquired

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<sup>887</sup> For example, the planning documents relating to the PMC highlight both the importance of the proximity of outpatient facilities to hospitals and the limited number of suitable locations available to HCA. Similarly, HCA highlighted the limited availability of suitable sites in close proximity to its London Bridge Hospital in its planning application for the Shard.

<sup>887</sup> Appendix 1 to Planning Statement:

<http://transact.westminster.gov.uk/CSU/Planning%20Applications%20Committees/2008%20onwards/2008/47%20-%204%20December/ITEM%201%20-%2015-17%20Lodge%20Rd,%20NW8.PDF>.

<sup>888</sup> [www.theprincessgracehospital.com/contact-us/general-enquiries/](http://www.theprincessgracehospital.com/contact-us/general-enquiries/).

in the Shard. We noted the current capacity constraints of the London Bridge Hospital. We considered that a purchaser of the London Bridge could operate effectively with the current capacity of the hospital but that it would find it difficult to grow its volumes without additional capacity. However, we also took into account the fact that the Princess Grace Hospital was included in the divestiture package and that these two hospitals, in combination with HCA's other central London competitors, should provide the insurers with sufficient non-HCA alternatives to allow them to switch their volumes away from HCA. We considered this to be the key criterion for the effectiveness of the divestiture package and concluded, therefore, that the Shard would not need to be included with the London Bridge Hospital for the remedy to be effective. We noted that a purchaser could also seek to expand its consulting and outpatient facilities (either in the Shard or elsewhere in the City or Southwark) in the longer run if it thought that it could grow its revenues by doing so.

○ *Other potential divestiture options*

11.137 We observed that following the divestiture of either the Wellington or the London Bridge and Princess Grace hospitals, HCA would retain a relatively high share of admissions and revenue in both oncology and obstetrics and gynaecology (on the basis of the 2011 figures). See Figure 11.6.

11.138 Much the same pattern is evident (see Figure 11.7) if share of revenue is considered instead of share of admissions, though some specialisms appear much more important in revenue than patient volume terms, for example cardiology, and others less so, for example gastroenterology.

FIGURE 11.6

**HCA and non-HCA hospitals' share of supply of admissions by specialism, 2011**

[✂]

Source: HCA.

FIGURE 11.7

**HCA and non-HCA hospitals share of supply by revenue, 2011**

[✂]

Source: HCA.

11.139 We considered whether this high share in these specialisms would render the divestiture remedy ineffective as insurers would still be unable to switch a substantial amount of their volumes away from HCA.

11.140 First, we considered first how quickly or easily a new owner of the HCA hospitals could expand into these two specialisms. One of the features giving rise to the AEC that we have identified is that barriers to entry are high in central London and we have concluded that the difficulty of finding an appropriate site for a general hospital and obtaining planning permission for it are particularly important. We also noted that the process of finding, obtaining planning permission, building and fitting out a general hospital could take several years. Divesting HCA's hospitals to a rival will eliminate this barrier since the new operator will have immediate access to a fully-functioning hospital. We therefore considered whether other barriers might deter,

hinder or prevent the acquirer of an HCA hospital from providing or expanding coverage of these specialisms.

- 11.141 We considered that, hypothetically, difficulties in attracting and retaining consultants in those specialisms because of pre-existing relations with HCA could prevent or hinder the hospital's new owner from doing so. However, we noted that both the London Bridge and the Wellington currently offer oncology and obstetrics and gynaecology services, indicating that they already have appropriate consultants practising at the facilities. Moreover, we have concluded that, on balance, we had insufficient evidence that consultant incentive schemes constituted a barrier to entry or expansion. Further, because we had other competition concerns as regards such arrangements, we are adopting measures to restrict or prohibit them. We therefore concluded that a rival to HCA would not be prevented from expanding their services in these specialisms because of difficulties in attracting or retaining consultants.
- 11.142 On this basis we concluded that although divesting the Wellington or London Bridge hospitals together with the Princess Grace will leave HCA with a large share of supply in oncology, obstetrics and gynaecology, the rival or rivals acquiring these hospitals will generally have the ability to begin providing or expanding their provision of services within those specialisms.
- 11.143 We also noted that the time it might take an operator to expand the volume of services undertaken in oncology or obstetrics and gynaecology could vary. We considered that where new treatments would need to be added in high-acuity specialisms or where it would be necessary to acquire major pieces of equipment, this might delay the rate at which the new rival could expand. For example, we reasoned that a rival that wished to provide advanced radiotherapy treatments, such as Cyberknife or Gamma Knife, would need both to acquire the equipment, configure its facilities for its use<sup>889</sup> and recruit appropriately-trained support staff in order to attract consultants and thereby patients to the hospital. We considered that this might delay the point at which HCA was effectively constrained by its rivals, although we concluded that the length of the delay was unlikely to be sufficiently significant to compromise the overall effectiveness of the remedy. For example, we considered that specialist staff could be recruited and equipment acquired relatively quickly (ie within six months). In addition, we did not consider that the adaptation of a hospital for a particular type of equipment (if required at all) would take more than six months provided the hospital had some spare capacity. However, we also considered whether a modified remedy package could address the AEC more swiftly.
- 11.144 In the case of obstetrics and gynaecology, because the majority of HCA's provision is through the Portland Hospital it would be necessary to divest this hospital in addition in order to provide the acquirer with an appreciably higher share of this specialism. We considered that requiring HCA to divest the Portland in addition to the other hospitals in the proposed package would be disproportionate, given that both the Wellington and the London Bridge hospitals already carry out some obstetrics and gynaecology work and therefore provide a platform for the expansion of this specialism. We considered that divesting the Portland instead of one of the major general hospitals would limit the remedy's effectiveness because of the reduced coverage of specialisms.
- 11.145 We next considered whether the divestiture package could be modified to provide the acquirer with a higher share of oncology admissions and revenue. As with obstetrics and gynaecology, HCA's share of supply in oncology is concentrated in specialist

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<sup>889</sup> Such equipment may require lead-lined rooms for safe operation.

hospitals and clinics: the Harley Street Clinic and LOC together with its associated clinics at a variety of hospitals.<sup>890</sup> We reasoned that it would be disproportionate to require HCA to divest, for example, the Harley Street Clinic or LOC in addition to the Wellington or London Bridge and Princess Grace. Replacing either the Wellington or London Bridge with the Harley Street Clinic would reduce the impact of the divestiture in other specialisms. We therefore considered whether other options were available.

11.146 We considered whether HCA's existing PPU facilities at University College Hospital, which specializes in cancer treatment (Harley Street at UCH), or the PPU it plans to open in 2016 in conjunction with Guy's and St Thomas' Trust at the new NHS Cancer Centre close to Guy's Hospital, would, if divested, address our concerns as regards HCA's residual share of oncology.

11.147 We noted that Harley Street at UCH did, indeed, specialize in the treatment of cancers but was highly specialized within its field, concentrating on the treatment of blood disorders in particular. Clinical oncology, for example, represents a relatively small proportion of its activity.<sup>891</sup> We considered that divesting so specialized a unit, whose focus might be difficult to change because of its governance, would be unlikely to address our concerns regarding HCA's residual share of oncology. We also had concerns regarding the practicability of divesting what is in effect a PPU management contract.

11.148 We next considered whether requiring HCA to divest its contract to operate a PPU in conjunction with Guy's and St Thomas' NHS Healthcare Trust (GST) would address our concerns. HCA has entered into an agreement with GST to operate a PPU within the integrated Cancer Centre<sup>892</sup> that is being built close to Guy's (and to the London Bridge) Hospital. This centre is scheduled to open in 2016. However, as part of its agreement with GST, HCA will be providing radiotherapy services prior to 2016 from the basement of the adjacent Borough Wing, using a linear accelerator. We noted that, by relocating some or all of HCA's existing cancer treatment to the PPU, it anticipates releasing capacity at the main London Bridge site itself, thus facilitating expansion in other specialisms there. The Cancer Centre will not open until 2016 and its inclusion in the divestiture package would not have any effect until then. On this ground alone we consider that a remedy requiring the divestment of the GST PPU is unlikely to be effective. Further, we do not know what volume of patients or revenue the PPU will generate so it is not possible to be certain whether its scale of operations would be large enough to constrain HCA. Finally, we had concerns over the practicability of transferring the management of the proposed PPU, for example whether GST would be willing to accept another operator. We therefore concluded that requiring HCA to divest this PPU would not address our concerns as regards its residual share of supply in oncology.

11.149 On this basis, we concluded that there were no alternative effective or less intrusive divestiture packages than either the Wellington Hospital and PMC, or the London Bridge and Princess Grace hospitals.

- *Different ownership scenarios*

11.150 We next considered whether the design of the divestiture package should take into account different ownership scenarios: whether the acquirer already owned hospitals

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<sup>890</sup> For example, [Harley Street at the Wellington Hospital](#).

<sup>891</sup> The PPU's revenue from clinical oncology in 2011 was approximately £[redacted] million but haematology generated £[redacted] million.

<sup>892</sup> [www.guysandstthomas.nhs.uk/our-services/cancer/cancer-centre/cancer-centre.aspx](http://www.guysandstthomas.nhs.uk/our-services/cancer/cancer-centre/cancer-centre.aspx).

or other medical facilities in central London and, if two hospitals were divested, whether it would matter whether they were bought by the same party or not.

11.151 If the purchaser of any of the HCA hospitals already owned a central London hospital, it would be necessary to consider whether the merger would give rise to any fresh competition concerns. We considered it unlikely that any of the existing operators of the larger hospitals in central London would be able to purchase the divested hospitals. In the case of the charities,<sup>893</sup> they might have difficulty in raising the funds or, in the case of larger commercial operators with a presence in central London, this could give rise to fresh competition concerns.<sup>894</sup> In these circumstances, the CMA might conclude that the operators concerned were not suitable purchasers. Were a commercial operator with a very small business in central London to purchase either or both of the hospitals, the fact that they held only a small share of supply would extinguish any competition concerns.

11.152 Finally we considered whether, in the case of the divestiture package containing the London Bridge and Princess Grace hospitals, we should specify whether the same purchaser could or should acquire both elements of the package. We thought that there was no need to specify this at this stage and that the CMA should take a view, bearing in mind the particular circumstances of the proposed transaction, at the time.

- *Other considerations of effectiveness*

11.153 In this section, we examine the other arguments put forward by HCA in relation to the likely effectiveness of a divestiture remedy, including the potential impact of PMI non-recognition and the extent to which any price benefits would be passed through to patients.

- *PMI recognition*

11.154 We considered HCA's argument that the divested hospital(s) might not be viable if it did not achieve PMI recognition or that, if the insurers were able to force its prices down, it might be unable to continue to provide the range of treatments and level of quality that HCA's hospitals currently provide. In the first instance, we noted that both AXA PPP and Aviva told us that their strategy in relation to the central London market would be to recognize all the major hospitals (which they considered to be the London Bridge, the Wellington and TLC) but to have a tiered offering in which access to more expensive hospitals was limited to policyholders who had selected a premium policy. Bupa did not make a submission on this specific topic; however, we observed that it has generally operated a policy of recognizing all facilities in the past, albeit in some cases recognition has been delayed while prices were negotiated. We did not consider, therefore, that an insurer would need to derecognize particular hospitals in order to obtain the price benefits that would result from a more competitive market. As a result, we considered it unlikely that a major insurer would derecognize either the divested or the retained HCA hospitals.

11.155 Second, we did not agree with HCA's argument that derecognition by an insurer would necessarily imply that a hospital would not be viable. We have not found that insurer recognition is a barrier to entry or expansion (see Section 6). We recognized that the lack of PMI recognition has previously forced hospitals to exit or to be sold to a competitor with recognition. However, we have also observed that in other areas of the country, hospitals that have been derecognized have sought to replace insured

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<sup>893</sup> TLC, St John and St Elizabeth's and King Edward VII.

<sup>894</sup> For example, Bupa Cromwell or BMI (the London Independent and Blackheath).



volumes with NHS or self-pay patients. In central London, we thought that the existence of a significant level of demand from both the overseas and self-pay markets would allow a hospital to maintain its viability if it did not obtain recognition from one of the major insurers. In addition, while central London hospitals currently do a minimal quantity of NHS work, we reasoned that an operator that needed to increase volumes could seek to develop this segment of the market.

11.156 In paragraph 11.181, we set out our proposal to require the PMIs to roll over their recognition of the divested hospital(s) for a period of 18 months. We note that this provision was to help ensure that HCA attracted suitable purchasers for the divestiture package and received a fair market value.

○ *Pass-through of price benefits*

11.157 We next considered HCA's arguments that any reduction in prices that did result from our divestiture remedy would not benefit insured patients as the insurers would not pass the benefit through. HCA argued that the CC could not treat insurers as customers and that their incentives were not aligned with those of patients. It argued that the CC should, therefore, conduct a detailed analysis of the likely pass-through of benefits to insured patients in order accurately to assess the proportionality of its remedies.<sup>895</sup> HCA noted that the nature of competition in the PMI market affected the level of pass-through. It said that the PMI market had an oligopolistic structure (the four major PMI providers—Bupa, AXA PPP, Aviva and PruHealth—accounted for 87 per cent of the market in 2012) and that the degree of pass-through was, therefore, likely to be low.<sup>16</sup> HCA stated that there was a misalignment between the incentives of PMIs and patients<sup>896</sup> and submitted that the PMIs' resistance to quality improvements and innovation was consistent with an uncompetitive PMI market, where PMIs saw little incentive to improve the quality of their offering to policyholders in order to attract new patients.<sup>17</sup> Furthermore, HCA considered that its view of the lack of competition in the supply of PMI was supported by the existence of captive PMI policyholders who were unable to switch in response to changes in the value of a PMI's offering. HCA argued that a recent decline in Bupa's loss ratio provided evidence that it had been able to extract increases in premiums above the increase in claims costs, increasing its profits. HCA asserted that this demonstrated that the insurers had not passed any cost savings through to policyholders in the past and that this strongly suggested they would not do so in response to any price declines that resulted from the divestiture of any of HCA's hospitals.<sup>897</sup>

11.158 We disagreed with HCA's arguments on two grounds. First, we note that our responsibility in designing and implementing remedies as part of a market investigation is, in relation to each AEC, to take such action under section 159 or 161 of the Act as we consider to be reasonable and practicable:

(a) to remedy, mitigate or prevent the AEC concerned; and

(b) to remedy, mitigate or prevent any detrimental effects on *customers*<sup>898</sup> so far as they have resulted from, or may be expected to result from, the AEC.<sup>899</sup>

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<sup>895</sup> [HCA response to provisional decision on remedies](#), paragraph 6.26.

<sup>16</sup> *ibid*, paragraph 6.26.

<sup>896</sup> *ibid*, paragraph 6.21.

<sup>17</sup> [Supplemental submission following HCA's remedies hearing](#).

<sup>897</sup> [HCA response to provisional decision on remedies](#), paragraph 6.35.

<sup>898</sup> CC emphasis added.

<sup>899</sup> [Section 138](#) of the Act.



- 11.159 We have found AECs arising from a lack of local competitive constraints combined with barriers to entry and expansion in relation to the provision of private hospital services to self-pay patients in local markets where there are weak competitive constraints outside central London and to self-pay and insured patients in central London. We estimated that this gave rise to detriment of between £154 million and £175 million a year.<sup>900</sup> This detriment takes the form of higher prices charged to customers in the private healthcare market, including self-pay patients, insurers and insured patients. We consider that it is appropriate for our remedies to seek to address the AECs and the consequent detrimental effects on these customers.<sup>901</sup>
- 11.160 The divestiture remedies, as well as the other remedies we propose implementing, would have the effect of increasing the competitive constraints acting on the private hospital operators, exerting downward pressure on prices and encouraging competition on quality and innovation. These price benefits would be enjoyed directly by the customers, ie self-pay patients, insurers and insured patients (to the extent that they make co-payments). We note that, as funders of private healthcare, insurers are customers of HCA and we consider that it is appropriate to treat them as such. Any quality or innovation benefits that arise from the divestiture remedy would accrue directly to the patients treated at these facilities, whether self-pay, insured or NHS.
- 11.161 Second, we consider that even when we examine the likely extent of pass-through to the ultimate consumers, we do not agree with HCA's argument that it is likely to be low.
- 11.162 We observe that the benefits arising from our remedies will be passed in full to self-pay patients who accounted for approximately [%] per cent of HCA's revenues in 2011.
- 11.163 Similarly, in the case of corporate trusts, the benefits of price reductions are passed directly to the employer who funds the scheme. We do not have figures for the proportion of HCA's revenues accounted for by such trusts. However, for the market as a whole corporate trusts comprised around 15 per cent of the total claims expenses of the insured market, or around 11.5 per cent of the total private revenues of the hospital operators.<sup>902</sup>
- 11.164 According to Laing & Buisson, international patients comprise approximately 3 per cent of the total revenue of private hospital operators in the UK.<sup>903</sup> However, this figure is significantly higher in central London with approximately [%] of HCA's revenues in 2011 being derived from international patients. Of these revenues, over two-thirds are self-funded or funded by embassies, such that any price benefits would accrue directly to these consumers.<sup>904</sup>
- 11.165 On this basis, we concluded that any price benefits would be enjoyed directly by around 40 to 45 per cent of the ultimate consumers in the market.

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<sup>900</sup> See Section 10.

<sup>901</sup> We include insured patients in this context since they are often liable for some portion of the costs of their treatment via excesses on their policies, as well as, in some cases, co-payments. As a result, they directly fund part of their treatment even when covered by insurance.

<sup>902</sup> In the case of corporate trusts, the prices paid by the trusts on behalf of claimants are those agreed between the PMIs and the private hospital groups. Corporate trusts account for approximately 15 per cent of the claims paid by the insured sector (Laing & Buisson Health Cover, UK Market Report, 2013, p30). On the basis that insured patients comprise 55.1 per cent of the total income of private hospital operators (Laing & Buisson, Private Acute Medical Care 2013 UK Market Report, p13), this equates to approximately 8 per cent of the total revenues of the private hospital operators, or around 11.5 per cent of their private (non-NHS) revenues.

<sup>903</sup> Laing & Buisson, Healthcare Market Review, 2013–2014, p32.

<sup>904</sup> Where medical treatment is funded entirely by a third party, eg for corporate trusts and for embassy-funded patients, we consider it logical to treat the funder as the end-consumer.

11.166 We next examined the insured sector. We observed that in the case of insured patients, economic theory indicates that even a monopolist would pass through a proportion of the reduction in cost, with a competitive market resulting in substantially all the benefit being passed to patients. We thought that the insured sector could be divided into large corporate customers on the one hand and SMEs and individuals on the other.

11.167 Bupa told us that large corporate customers had their insurance policies priced according to the company's own claims history and that this had the effect of shifting risk on to the insurer. It stated that, when prices were increased after a year of higher claims, corporates could often switch to another insurance provider, whereas when claims had been lower than expected, the corporate typically demanded a price decrease during the next year. This meant that insurers often struggled to recover losses made during high claims years. Moreover, Bupa explained that the majority of corporate purchases were made through brokers and intermediaries, meaning that there were sophisticated purchasers who knew where to find value for money in the market. For example, at end December 2011, on Bupa's corporate book [redacted] per cent of lives covered and [redacted] per cent of organizations were intermediated.<sup>905</sup> Similarly AXA PPP told us that the private medical insurance market for large corporate customers was highly transparent, with pricing based on the costs incurred by insurers in the previous period. We thought that evidence provided by Bupa on the relative loss ratios across corporate and other insurance policies supported the contention that the corporate market was relatively competitive.<sup>906</sup> We concluded that this indicated that a significant proportion of the cost reduction would be likely to be passed through in this segment.

11.168 We thought that the argument put forward by HCA regarding pass-through was also contradicted by [redacted].

11.169 The large corporate segment accounts for 22 per cent of the total PMI market and is likely to comprise a larger proportion of claims costs (and hence revenues to private hospital operators) due to the higher loss ratios on this business.<sup>907</sup> Even assuming that it accounts for only 22 per cent of insured spend with private hospital operators, this comprises 17 per cent of the total private revenues generated by these businesses.<sup>908</sup>

11.170 Finally, we considered the likely pass-through to SME businesses and individual policyholders. As noted above, economic theory indicates that at least a proportion of the price benefits resulting from any divestiture remedies would be passed through to policyholders, even if the PMI market were not fully competitive. We considered the evidence put forward by HCA in respect of Bupa's loss ratios and compared it with data we had collected on the loss ratios and combined ratios of the three largest insurers over the relevant period (see Figure 11.8). We noted that our information did not show either the same trend as that asserted by HCA (based on Laing & Buisson

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<sup>905</sup> Bupa explained that companies insuring 50 or fewer employees were categorized within the SME segment, those with more than 250 employees in the 'large corporate' segment and those in between could be treated as either depending on the business's preference and a number of other factors.

<sup>906</sup> Bupa's figures indicated a loss ratio on corporate policies of around [redacted] per cent, compared with a loss ratio of around [redacted] per cent overall.

<sup>907</sup> According to Laing & Buisson (Health Cover, UK Market Report 2013, p23), large corporate customers spend approximately £957 million on private medical cover, out of a total of £4,420 million (including individual policies and corporate trust spending). This equates to approximately 22 per cent of the insured market. We note that as loss ratios tend to be higher for large corporate customers, we expect them to account for a higher proportion of claims costs, ie spending on private healthcare services.

<sup>908</sup> PMI customers accounted for 55.1 per cent of private hospital operators' income in 2012 and 76 per cent of their total private income (stripping out the 27.5 per cent of income generated by treating NHS patients). Laing & Buisson (Private Acute Medical Care 2013 UK Market Report, p13).

information) or the same level of loss ratio.<sup>909</sup> Loss ratios over the period appeared to us to be reasonably stable across all three insurers. The combined ratios were also relatively stable across the period and very similar across the three largest insurers. While it would not be possible to conclude from this information whether a reduction in costs would be passed to patients or not, we observed that the level of the combined ratio did not suggest that the insurers were making large margins on their PMI products. We thought that this was consistent with a market in which there would be a high level of pass-through of a reduction in costs.

FIGURE 11.8

### PMI loss ratios and combined ratios

[REDACTED]

Source: CC analysis.

11.171 We noted HCA's argument that the cost of claims paid to HCA was only one element of insurers' variable costs and that a number of policies did not include HCA hospitals. HCA suggested that this meant that any price reductions would only affect a limited number of PMI policies and only have a limited impact on PMI's costs.<sup>910</sup> We did not consider this argument to be relevant to the question of pass-through, which logically examines what proportion of the cost savings are passed to consumers, not what proportion of total costs incurred by consumers such savings represent nor what proportion of consumers benefit from the reduction.

11.172 In light of the above discussion and analysis and given the conservative nature of our assumptions in estimating the price benefits of divestiture, we concluded that it was reasonable to take into account the full reduction in prices when assessing the proportionality of our divestiture remedy.

- *Availability of suitable purchasers*

11.173 We considered whether there was a risk that a suitable purchaser would not be found for the divestiture package or that HCA might dispose to a weak or otherwise inappropriate purchaser.

11.174 HCA suggested that by requiring it to divest assets that it had legitimately acquired and developed, the CC might deter investors from making further investments in the UK market, including acquiring any divested hospitals. We do not consider these concerns to be well founded given the level of interest in the central London private healthcare market from both existing operators and overseas businesses. For example, [REDACTED], whilst both [REDACTED] and [REDACTED] expressed an interest in acquiring hospitals in central London. Spire told us that there was likely to be interest in acquiring hospital assets from a large number of potential purchasers, including the larger, UK-based hospital operators, smaller UK-based operators, international operators, insurers, private equity firms and the NHS. [REDACTED]<sup>911</sup> In addition, [REDACTED] approached the CC since the publication of the provisional findings, expressing an interest in purchasing hospital assets. Nueterra also expressed an interest in entering the UK market.<sup>912</sup>

<sup>909</sup> The information provided to the CC by [REDACTED].

<sup>910</sup> [HCA response to provisional decision on remedies](#), paragraph 6.36.

<sup>911</sup> [Ramsay hearing summary](#).

<sup>912</sup> [Nueterra response to provisional findings and remedies notice](#).

11.175 In order to ensure the success of divestiture remedies, the CMA will require that prospective purchasers meet our suitability criteria, which are consistent with our market guidance.<sup>913</sup> In summary, we will wish to satisfy ourselves that all prospective purchasers:

- (a) are independent of the divesting party (HCA), such that the purchaser is able to compete vigorously;
- (b) have appropriate financial resources, expertise and assets to enable the divested business to be an effective competitor in the central London market. Appropriate financial resources include a capital structure of the purchaser that permits adequate resources to continue to develop the acquired hospitals as competitive entities. Appropriate expertise would include expertise and experience in operating hospitals which provide high-acuity treatments across a range of specialisms;
- (c) have an appropriate business plan and objectives for competing in the central London private healthcare market; and
- (d) do not raise further competitive or regulatory concerns.

11.176 As set out in paragraphs 11.150-11.152 We considered whether the effectiveness of the remedy would depend on whether, if divested, the London Bridge and Princess Grace hospitals were sold to the same or different buyers and whether, at this stage, it would be appropriate to specify this. We concluded that we should not specify this now but decide in the particular circumstances of the sale, taking account of the characteristics and resources of the potential purchasers.

11.177 We considered HCA's argument that condition (d) would rule out any existing central London providers, which HCA claimed were the only UK-based providers which had a track record of operating high-acuity hospitals, and therefore was incompatible with condition (b). We did not agree that this was likely to be the case. As set out in paragraph 11.173, we expect that HCA's hospitals will attract significant interest from a broad range of purchasers, including the operators of high-acuity facilities in the UK and overseas. Moreover, condition (d) would not necessarily exclude all existing providers in the central London market depending on the competitive position and the assets to be acquired. For this same reason, we did not agree that the conditions set out above would jeopardize HCA's ability to obtain a fair market price for its assets by narrowing down the pool of potential purchasers.

- *Effective divestiture process and divestiture period*

11.178 We will require that an effective divestiture process takes place which protects the competitive potential of the divestiture package before disposal and enables a suitable purchaser to be secured in an acceptable time frame whilst enabling the vendor(s) to achieve an appropriate market value from the sale.

11.179 The main concern that parties raised in this respect was the potential for HCA to encourage consultants practising at the divestiture hospital(s) to move their practice to other hospitals within the HCA group. This would both divert revenue back towards HCA and potentially undermine the viability of the hospital being divested. A second concern was that a lengthy divestiture process may disrupt the operations of the divestiture hospitals and create uncertainty for staff, potentially encouraging them to leave and thereby damaging the performance of the divestiture package. Certain

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<sup>913</sup> CC3, [Annex B](#), Remedial Action, paragraphs 17–22.

hospital operators expressed concerns that insurer recognition would cease on sale and this would impose a major uncertainty on purchaser interest. Finally, several parties expressed views as to whether the hospitals to be divested should be sold individually, or should be 'bundled' together.

11.180 We considered these submissions in the light of our guidelines on divestiture remedies and the risks that may arise when the CC implements a divestiture remedy. These comprise composition, purchaser and asset risks.<sup>914</sup> Our guidelines state that divestiture risks can be overcome, at least in part, through the design of the divestiture and by adopting protective measures such as the appointment of monitoring and divestiture trustees and alternative divestment packages.<sup>915</sup>

11.181 We considered that it would be appropriate to adopt the following measures to ensure an effective divestiture process:

- (a) Accept undertakings from or implement an order which imposes a duty on HCA to maintain the business being divested in good order and not to undermine its competitive position. In particular, we would require a commitment from HCA not to encourage or induce consultants or key nursing or technical staff currently practising or employed at the divested hospital(s) to move their practise (or employment) to the group's retained facilities,<sup>916</sup>
- (b) Require HCA to appoint a monitoring trustee, paid for by it but approved by and reporting to the CMA in accordance with a mandate approved by the CMA, to monitor HCA's compliance with the undertakings or order.
- (c) Require HCA to inform the CMA which of the two divestiture options it intends to adopt within 30 days of the commencement of the initial divestiture period.
- (d) Require the insurers to roll over their existing contract terms with the divested hospitals for a period of 18 months from the date of divestiture, whilst permitting a shorter period by mutual agreement. In choosing this 18-month period, we sought to balance the need to prevent disruption to patients and to enable HCA to receive an appropriate market value from the sale by obviating the risk of losing insurer recognition, against the desire to ensure that competitive constraints were increased as soon as possible to remedy the AEC.
- (e) Specify a sufficient but not excessive time frame for an orderly divestiture process to enable a suitable purchaser to be secured in an acceptable time frame whilst enabling the vendor(s) to achieve an appropriate market value from the sale. We discuss what an appropriate divestiture period might be below.
- (f) If HCA has not entered into a binding agreement to sell the divestiture package to a suitable purchaser by the end of the specified divestiture period, the CC will have power to appoint an independent divestiture trustee to dispose of the package(s) within a further specified period to a suitable purchaser for the best terms available in the market circumstances but without a reserve price.

11.182 The large majority of respondents to the Remedies Notice, including Spire, Nuffield and TLC, suggested that a six-month time frame would be sufficient for the divestiture of hospital facilities. We considered HCA's argument that a time frame of

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<sup>914</sup> CC3, Annex B, paragraph 6.

<sup>915</sup> An alternative divestment package may comprise a more extensive package which is considered may be easier to market in the event that a buyer cannot be found for the original package.

<sup>916</sup> In this respect, we note that our remedy regarding consultant incentives should act to reinforce these undertakings by preventing hospitals from making direct payments either in cash or in kind to consultants.

between [X] and [X] months would be required due to the complexity of separating its hospitals from the rest of its network, the need to put in place transitional arrangements to ensure continuity of care and the time that buyers will require to undertake detailed due diligence. However, we noted that almost all of the same issues would need to have been addressed by Nuffield when it sold nine of its hospitals to BMI in 2008 and that this divestiture was completed within approximately six months. Moreover, we took into account the fact that a number of potential purchasers have already expressed an interest in acquiring central London hospital assets, which suggests that a lengthy marketing phase would not be required.

11.183 On this basis, we considered that a time frame for the initial divestiture period of [X] months would be feasible. However, to ensure that the vendors have sufficient opportunity to achieve appropriate market value, we consider that a divestiture period of [X] months is appropriate from the date of acceptance of undertakings or the making of a divestiture order. We consider that this period would also ensure that the AEC we have identified was addressed in a timely manner. In the event of a material change in circumstances, it is open to HCA to make submissions requesting an extension to the divestiture period and the CMA will consider whether any change is appropriate.

- *Previous OFT decisions*

11.184 We have considered the arguments put forward by HCA in relation to the previous OFT clearance of its acquisition of the St Martin's hospital group in 2000. We also note that when in 2001 HCA sought to acquire significant interests in the London Heart Hospital, the OFT referred the matter to the CC and HCA then abandoned the proposed transaction.

11.185 We noted that markets evolve and change over time, as does the nature of the analytical tools used by the competition authorities. Given this, there may be a number of reasons why a different analytical approach may be taken by the relevant authorities at different times and under different legislative frameworks. In addition, in a market investigation far greater data may be available as well as sufficient time to undertake more detailed analysis. In the present investigation we have examined in detail the characteristics of the hospital operators, the characteristics of each hospital's location and patients, the prices charged and the profits generated. In addition, the Act gives the CC power to include the structural remedy of divestment and this is not circumscribed by previous regulatory interventions in the way submitted by HCA. Moreover, just as the OFT and the CC are not precluded from adopting different analytical techniques in different cases and departing from their previous decisions when appropriate, we considered that our proposed divestment remedy did not introduce a form of 'double jeopardy' or give rise to a 'breach of legitimate expectations', nor was our market investigation or the appropriateness of particular remedies restricted by decisions taken over a decade earlier under a different regime.

*Consideration of costs and benefits of divestitures*

11.186 In this section, we consider in detail the costs and benefits that are likely to result from our proposed package of divestitures.

- *Costs of divestiture*

11.187 HCA argued that the CC's proposed divestiture remedy as set out in the provisional decision on remedies, comprising the London Bridge and Princess Grace hospitals,

would result in a number of costs that had not been adequately taken into account in our analysis. HCA said that it considered there would be:

severe negative impacts on quality, investment and innovation that will arise from the proposed divestitures, all of which constitutes a relevant cost of the CC's remedies that the CC must take into account. In addition, the divestment will lead to a loss of economies of scale, which also amounts to a loss of RCBs, and therefore a relevant cost of the CC's divestiture remedies.<sup>917</sup>

In this section, we consider each of the categories of RCBs put forward by HCA in turn, setting out the conclusions that we have reached.

11.188 In addition, HCA argued that by forcing it to divest one or more hospitals at a time that was not chosen by the business and by limiting the pool of potential purchasers, the remedy would result in the divestment of its assets at below their fair market value. HCA stated that:

the CC has failed to understand that the forced divestiture leads to a loss of value to the business for reasons unrelated to any change in competitive conditions in the market. The forced divestiture removes the flexibility and choice available to HCA and this imposes real costs on the business, regardless of the number of purchasers that might be involved in bidding for the proposed divested HCA hospitals. Absent a forced divestiture, HCA is free to consider its exit strategy unconstrained, and to optimally select the time and manner of any potential exit. The proposed forced divestment removes this flexibility, as well as prescribing the pool of potential buyers, which means that the value HCA receives from a forced sale ... does not represent a 'fair market value'.

○ *Loss of quality, investment and innovation in healthcare provision*

11.189 HCA put forward the argument when commenting on the provisional decision on remedies that the divestiture of its two hospitals would result in a reduction in the quality of private healthcare provision in London. It said that there was a real possibility that an alternative operator of its divested facilities may choose to follow a different strategy, not adopting HCA's strategy of high-quality, high-acuity care and also delivering less investment and innovation. In this case, HCA emphasized that the remedy would be ineffective as it would not create a new, high-quality competitor to HCA's remaining hospitals. Furthermore, HCA argued that the divestiture remedy would deprive it of operational economies of scale, reducing its ability to offer integrated patient pathways, which is one factor that HCA considered drove the quality of its service offering.<sup>918</sup>

11.190 HCA argued that by forcing it to divest some of its assets, the CC may create a chilling effect on investment across the private healthcare sector, not just in terms of businesses seeking to acquire the divested hospitals but in terms of the ongoing investment in those hospitals 'since purchasers will be aware that should their

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<sup>917</sup> [HCA response to provisional decision on remedies, Annex 2](#), paragraph 1.66.

<sup>918</sup> [ibid](#), Annex 2, paragraphs 1.69–1.74.

investments lead them to achieve higher market shares they will be at risk of forced divestiture and the costs on their business that this entails’.<sup>919</sup>

11.191 Appendix 11.1 sets out in detail our consideration of HCA’s arguments regarding the loss of quality in healthcare. In this section, we summarize our assessment of these arguments and our conclusions.

11.192 We first considered HCA’s arguments that it provided higher-quality healthcare and was more innovative than its competitors in central London. HCA made extensive submissions in this respect, and these are discussed in detail in Appendix 11.1. We concluded that the evidence we had seen indicated that HCA did provide good-quality healthcare services but it was not sufficient for us to conclude that HCA’s service quality was higher than that of close competitors in central London, such as St John and St Elizabeth, TLC and King Edward VII. Similarly, the evidence indicated that HCA was an innovative operator, adopting a range of new technologies over the relevant period. However, we found that other, smaller operators tended to innovate to a similar extent and, in some cases, adopted new technologies prior to HCA.

11.193 Next, we examined the argument that a purchaser of the divestiture package would be likely to pursue a different strategy from HCA, either as a commercial choice or because it was unable to enjoy the economies of scale that would permit it to invest in providing a high-quality and high-acuity service, and therefore would not provide an effective competitive constraint on the remaining HCA hospitals. We observed that in central London HCA and its competitors have generally sought to pursue a high-acuity, high-quality strategy because of the commercial attractiveness of these lines of business, and it seems likely to us that any acquirer would have the incentives to do the same. An acquirer would be equally aware of the high growth rate and profitability of more complex specialisms and would be likely to continue to invest in them.

11.194 We considered that the new owner or owners might seek to reposition themselves both vertically, in terms of quality, and horizontally, in terms of the types and range of services they offer were signals from the more competitive central London market to indicate that this was optimal. However, we did not agree with HCA’s argument that this would make the remedy ineffective as a purchaser following a different strategy, provided that this strategy was in line with what was demanded by the market, would exert a competitive constraint on HCA by competing for its customers. Therefore, we do not consider that an effective remedy is one where a purchaser necessarily follows exactly the same strategy as HCA, but only where it competes effectively for HCA’s customers across medical specialties. We thought that whether a purchaser pursued the same strategy as HCA, or a different one in response to market signals, the new competitive dynamics in central London would ensure that patients’ needs would be met at least as well as currently, if not to a greater extent.

11.195 We considered the ability of a new purchaser to pursue the same type of strategy without the economies of scale that HCA may derive from its network of London hospitals. In the first instance, we noted our requirement that suitable purchasers should have expertise and experience in operating hospitals capable of delivering high-acuity services to a high standard. The CMA would therefore be in a position to assess whether potential purchasers had the necessary ability, expertise and resources to provide high-quality services and to prevent purchasers that were not suitably qualified from acquiring the hospitals to be divested.

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<sup>919</sup> *ibid*, Appendix 2, paragraphs 1.90–1.97.



- 11.196 Second, our assessment of the evidence was that such economies of scale were not necessary to provide high-quality healthcare services. The examples provided by HCA of how an integrated care pathway could enhance quality outcomes for patients related mainly to cancer. We noted that TLC offered an integrated cancer service at its new centre, which indicated that such a care pathway can be created by a PHP with a (significantly) smaller scale than HCA. Finally, we thought that consultants would still be able to refer patients to whichever hospitals they considered best able to treat them, whether owned by HCA or another operator. While we could see the benefit to HCA of retaining patients for a full course of treatment, we did not consider that this was necessarily a benefit to patients.
- 11.197 We considered the ability/incentive of smaller operators to invest in providing high-quality and high-acuity services given their lower patient numbers. We observed that TLC has invested heavily in recent years in developing its offering in cancer treatment, despite being significantly smaller than HCA. Similarly, we noted that both Spire (in Brighton and Bristol) and BMI (at Chelsfield Park and Bishops Wood) had invested in Interoperative Radiation Therapy (IORT) technology at stand-alone hospitals, despite HCA's claim that such investments would not be possible unless leveraged across several hospitals. We concluded, therefore, that while a certain minimum volume of patients would be required to make certain investments commercially viable, there was evidence that HCA's competitors both within and outside central London were able to invest in these technologies or services despite operating on a significantly smaller scale than HCA. As a result, we thought that our divestiture remedy would be very unlikely to reduce either HCA or the divestiture package below this minimum scale and therefore would not deter investment in quality.
- 11.198 We examined HCA's argument that our divestiture remedy would have a chilling effect on investment across the healthcare sector by indicating to PHPs that 'should their investments lead them to achieve higher market shares they will be at risk of forced divestiture and the costs on their business that this entails'.<sup>920</sup> HCA also argued that our divestiture remedy would have a wider chilling effect on investment in other sectors in the UK as 'in this case, the CC has signalled that companies that invest and grow their businesses beyond a market share of 40 per cent are at risk of being required to divest substantial parts of their business, even if they have a strong and recognised record of providing high quality to their customers'.<sup>921</sup> Any reader of our report will be aware of the fact that our decision to require divestiture is taken following an in-depth and lengthy investigation which led to our finding that in this particular market there is an AEC and that the structural remedy based on the circumstances of the case is appropriate. We did not, therefore, consider that this was a significant risk as a result of our divestiture remedy.
- 11.199 In addition, we observed that HCA's market share was around three to four times larger than that of its closest competitor in central London, TLC, and that our proposed divestiture package would create another competitor of a relatively similar size to TLC. Following the divestiture remedy, therefore, either HCA or its competitors would need to grow their market share substantially in order to achieve the level of market share that HCA currently has, particularly in complex and high-acuity medical services. As a result, we did not consider that any of these operators was likely to be deterred from investing in developing and expanding its business by the potential threat of a future CMA market investigation.

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<sup>920</sup> *ibid*, Annex 2, paragraph 1.97.

<sup>921</sup> *ibid*, Annex 2, paragraph 1.98.

- 11.200 In terms of the range of treatments offered, we considered that HCA's evidence on choice of treatments showed that it had to a certain extent widened the range of, in particular, high-acuity treatments available outside the NHS. We noted that other hospitals in central London, however—for example TLC—had adopted a similar strategy.
- 11.201 On the basis of this assessment, we concluded that our divestiture remedy would be unlikely to result in a reduction in the quality or range of healthcare services in central London and therefore it would be inappropriate to take into account the loss of any RCBs in our assessment of proportionality. Indeed, as we explain in paragraphs 11.223 to 11.225, we considered that the increase in competition that would result from our divestiture remedy would be likely to increase investment in quality and innovation in the private healthcare market and that this was an additional benefit for customers.
- *Loss of economies of scale*
- 11.202 HCA told us that the economies of scale and scope that it was able to achieve from operating a network of hospitals resulted in lower prices for patients and therefore constituted an RCB that would be lost (or at least reduced) as a result of imposing divestitures on the business.<sup>922</sup> HCA argued that the CC's approach to economies of scale was inconsistent, with the CC recognizing the existence of economies of scale in its assessment of barriers to entry but not in the context of its proportionality assessment.<sup>923</sup>
- 11.203 HCA told us that it estimated that the loss of economies of scale and scope arising from the divestiture package would amount to £[REDACTED] million per year, comprising:
- (a) £[REDACTED] million of recharged central costs that would need to be covered by its remaining facilities;
  - (b) £[REDACTED] million of group costs;
  - (c) £[REDACTED] million from Sarah Cannon Research UK; and
  - (d) £[REDACTED] million from HCA laboratories.<sup>924</sup>
- 11.204 HCA argued that central costs could not, in general, be scaled back in proportion to the divestitures and there was no guarantee that the economies of scale could be replicated fully by a buyer, particularly where that purchaser did not already have a significant presence in the London market.<sup>925</sup>
- 11.205 In the first instance, we observed that our assessment of barriers to entry recognized the existence of significant economies of scale at the level of an individual hospital but it did not reach any conclusions regarding the level of economies of scale (or more accurately, scope) that exist across private hospital groups. Hence, we did not agree that there was any contradiction in the approaches taken in these areas.
- 11.206 Second, we did not consider that any economies of scale or scope enjoyed by HCA qualified as a relevant customer benefit as defined by the Enterprise Act 2002.<sup>926</sup> The

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<sup>922</sup> *ibid*, Annex 2, paragraphs 1.101 & 1.102.

<sup>923</sup> *ibid*, Annex 2, paragraph 1.103.

<sup>924</sup> *ibid*, Annex 2, paragraph 1.115.

<sup>925</sup> *ibid*, Annex 2, paragraph 1.117.

<sup>926</sup> [Section 134](#)(8).

Act states that RCBs are limited to benefits to relevant customers in the form of 'lower prices, higher quality or greater choice of goods or services' or 'greater innovation'. HCA asserted that its economies of scale permitted it to charge lower prices to patients. However, our IPA found that it charged insurers [£] per cent more on average for inpatient and day-case treatments between 2007 and 2011 than its closest competitor, TLC. Moreover, this difference was in spite of any advantage that HCA might have over TLC, a smaller, single hospital operator, in terms of economies of scale or scope. We concluded therefore that, to the extent that HCA did benefit from economies of scope or scale, it was not passing these on to its customers and, therefore, they did not qualify as an RCB. Furthermore, we considered that the loss of any such benefits would already be reflected in our quantification of the price benefits of divestiture using the results of the IPA since this analysis compared HCA's prices with those of a significantly smaller operator, TLC, which would not enjoy the same economies of scope. As a result, we thought it would be inappropriate to make any additional allowance for loss of economies of scale in our calculation of the NPV of the divestiture remedy. (We consider HCA's arguments regarding RCBs in terms of quality and innovation in paragraphs 11.189 to 11.201.)

11.207 Third, we noted that if there were significant economies of scale or scope (at the group level) in the provision of private healthcare services, we would expect that an advantaged suitable purchaser, or purchasers, of HCA's hospitals, which would include national or international groups, would be able to 'recreate' in their own businesses any lost economies of scale suffered by HCA. We did not agree with HCA's argument that such operators would necessarily need to have a significant presence in London in order to recreate these economies of scale or scope. We noted that the economies estimated by HCA related mainly to staff costs, including legal, HR, finance, informatics, billing, international marketing and business development teams.<sup>927</sup> We thought that a large proportion of these functions could be performed from an office outside London, or indeed outside the UK. HCA told us that it received support from its US Head Office in relation to [£].<sup>928</sup>

11.208 On this basis, we concluded that it would be inappropriate to include any loss of economies of scale in our 'base case' estimate of the NPV of our divestiture remedy. However, we have included the full loss of economies of scale put forward by HCA (£[£] million per year) in our 'downside case'. We consider this to be a highly conservative approach.

#### ○ *Transaction costs*

11.209 HCA estimated that it would incur transaction costs of between £[£] and £[£] if it were required to divest two of its hospitals, comprising M&A fees of between £[£] and £[£], legal fees of between £[£] and £[£], due diligence fees of between £[£] and £[£] and various other costs amounting to £[£]. HCA told us that the lower end of this range represented a sale to a single purchaser and the upper end represented a disposal to two separate purchasers, and suggested that we should use the upper end of the range (ie £[£] million) as 'it appears that the CC envisages two individual buyers for HCA's hospitals'.<sup>929</sup> In addition, HCA argued that the costs of a monitoring trustee should be taken into account, which HCA anticipated would be £[£] million.<sup>930</sup> Finally, HCA put forward the view that the CC should take into account the costs incurred by a purchaser of the hospitals, which it estimated at £[£] million.

<sup>927</sup> HCA response to provisional decision on remedies, Annex 2, Appendix 2.

<sup>928</sup> HCA response to provisional findings, Appendix 5, paragraph 5.129.

<sup>929</sup> HCA response to provisional decision on remedies, Annex 2, paragraphs 1.134 & 1.135.

<sup>930</sup> *ibid*, Annex 2, paragraph 1.136.

- 11.210 In order to review the reasonableness of these cost estimates, we asked Nuffield to provide us with details of the transaction costs it incurred in selling nine of its hospitals to BMI in 2008. Nuffield told us that it incurred total costs of approximately £4.3 million, comprised of £[X] million of legal fees, £[X] million fees for financial advice, £[X] of project management and bonus costs and £[X] of IT separation costs.
- 11.211 We observed that the total fees paid by Nuffield were [X] and we considered the latter to be within a reasonable range. We have not specified whether the divestiture package should be divested to a single purchaser or to two purchasers. However, we thought that it would be conservative to use the upper end of the range of fees estimated by HCA. We have, therefore, taken into account transaction fees of £[X] million for HCA, £[X] million for the purchaser(s) of the divested hospitals, and monitoring trustee fees of £[X] million, ie total transaction costs of £[X] million.
- 11.212 We thought that redundancy (and reorganization) costs would be incurred as a direct result of our divestiture remedy and the need to reduce the central business functions to reflect the smaller size of the business. HCA did not provide an estimate of the costs that it expected to incur in reorganizing its operations following the divestiture of two of its hospitals but it agreed with the estimate proposed by the CC in the provisional decision on remedies of around [£7–£9] million.<sup>931</sup>

○ *Divestiture at below fair value*

- 11.213 We examined HCA's argument regarding its assets being sold at below fair market value because the remedy would not allow it to choose the timing of the divestiture, which might restrict the pool of buyers. We did not think that this meant that HCA would receive a value that was below the fair market value but rather that it would receive the fair market value at the time at which the divestiture took place. We considered that the 'fair market value' of an asset must be judged at the point at which it is sold provided that the disposal process is conducted in a way that does not prevent HCA from achieving fair market value, and it is not appropriate to take into account, as a cost of the remedy, the possibility that at another time, the fair market value of the assets may be higher than at the point of sale. This view was supported by the CAT in its decision on BAA.<sup>932</sup>

○ *Quantification of costs of divestitures*

- 11.214 In conducting our cost-benefit analysis, we have taken into account the transaction costs of selling the hospitals, the reorganization and/or redundancy costs that HCA is likely to incur following divestiture in order to reconfigure its business in line with its reduced scale, and, in the downside case, loss of economies of scale of £[X] million per year. These costs are included in our estimate of the NPV of our divestiture remedies in paragraphs 11.227 to 11.239.
- 11.215 We have not taken into account any reduction in investment or innovation at either the divested hospital(s) or those retained by HCA, as proposed by HCA. As set out in paragraphs 11.223 to 11.225, our assessment of the private healthcare market indi-

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<sup>931</sup> *ibid*, Annex 2, paragraph 1.151.

<sup>932</sup> 'In performing a proportionality analysis ... we consider that it is appropriate that the fair value of Stansted should be assessed by the value the market will give it after there has been an appropriate opportunity to market it. This value will take account of its performance to an appropriate extent ie in circumstances undistorted by the AEC of common ownership and as assessed by the market, and BAA will receive the appropriate compensating payment (the market price) for giving up an asset with the potential for such future performance. The CC cannot be expected to be more perspicacious than the market in predicting and assessing the impact of future performance.' *BAA v Competition Commission*, February 2012, paragraph 78.

cates that investment is more likely to increase rather than decrease in response to additional competition. We also concluded that there was no evidence to suggest a reduction in the quality or range of treatments as a result of our divestiture remedy. Therefore, we have not included (or quantified) any loss of quality/range as a cost of our remedy. Finally, we concluded that HCA would be able to sell its assets at fair market value and therefore have not taken into account any costs associated with a sale at below fair market value.

11.216 HCA argued that our approach in quantifying the costs and benefits of divestiture was inconsistent as we had suggested that there would be more investment in quality and innovation following divestiture (a benefit) but we had not reflected the fact that this would result in higher prices for medical treatment, which would reduce our estimate of the price benefit.<sup>933</sup>

11.217 We did not agree with the logic of this argument. If the quality of a service improves as the result of a remedy, the higher price associated with the higher-quality service is not a ‘cost’ of the remedy unless the increase in price is proportionately larger than the improvement in quality. We considered that there was no reason to assume that, in a more competitive market, hospital operators would be able to extract disproportionately higher prices for their services. We have not, therefore, included such incremental investment as a ‘cost’ of the remedy.<sup>934</sup>

TABLE 11.8 CC estimates of costs of divestiture

£ million				
	Transaction costs	Other one-off costs (reorganization costs)	Loss of economies of scale	
			Downside case	Base (& upside) case
HCA	[£]	[£]	[£]	[£]

Source: CC analysis.

- *Benefits of divestiture*

11.218 We considered that there were likely to be two main benefits resulting from our divestiture remedy, namely a reduction in the prices charged to private patients and PMIs at both the divested hospital(s) and those retained by HCA, and an improvement in the quality of private healthcare services in the local markets where divestitures are required. In this section, we consider each of these benefits in turn.

- *Reduction in prices*

11.219 In Appendix 11.2, we have set out in detail the approach that we have adopted in estimating the likely reduction in prices that would result from our divestiture remedies, as well as our consideration of HCA’s criticisms of our approach. We reasoned that there were two basic methods that we could take to estimate the likely change in total revenues resulting from a change in concentration. The first was to apply the coefficient identified in our PCA analysis<sup>935</sup> to the changes in the weighted average market share of the hospitals to identify the price effect, which could then be

<sup>933</sup> [HCA response to provisional decision on remedies, Annex 2](#), Appendix 1, paragraphs 2.24 & 2.25.

<sup>934</sup> We thought that this argument was also inconsistent with HCA’s arguments set out in paragraphs 11.189 to 11.201, that we should take into account the loss of investment at both the divested and retained hospitals as a ‘cost’ of the remedy. On the logic put forward here, such decreases in investment would be counted as a benefit of the remedy.

<sup>935</sup> This coefficient (on the LOCI regression) translated into a reduction in price of 3.4 per cent in response to a 20 percentage point decline in the weighted average market share of a hospital (group).

applied to revenues to estimate the total impact on revenues that divestiture would have. The second approach was to use the results of our IPA to estimate the impact that divestiture would have on revenues on the basis that it was effective in reducing HCA's market power to a level equivalent to that of TLC.

11.220 We reasoned that the most robust approach was to apply the results of the PCA to self-pay revenues on inpatient treatments, as the analysis was based on this data, and to apply the results of the IPA to insured revenues on inpatient and day-case treatments. In our 'upside' case (only), we also applied the price difference between HCA and TLC measured in the IPA to HCA's international revenues (inpatient and day-case), but we assumed in our base case (and downside case) that there would be no effect of our divestiture remedy on the prices paid by international patients. We consider this to be a conservative assumption.

11.221 Table 11.9 shows our estimates of the likely impact on revenues of the divestiture of HCA's hospitals. Our base case estimates indicate total revenue benefits to customers of approximately £[X] million per year, while the upside estimate is of total revenue savings for customers of approximately £[X] million per year. This analysis suggests that the divestiture of the London Bridge and Princess Grace hospitals would have a greater impact on prices than the divestiture of the Wellington. However, we thought that the differences were not sufficiently substantial to give us a reason to consider one of these divestiture packages to be more effective than the other.

TABLE 11.9 Impact of HCA divestitures on private patient revenues

Divestiture package	Revenue stream	Revenue reduction (£'000)	
		Downside & base case	Upside
HCA London Bridge & HCA Princess Grace	Self-pay	[X]	[X]
	Insured	[X]	[X]
	Overseas	[X]	[X]
	<b>Total</b>	[X]	[X]
HCA Wellington	Self-pay	[X]	[X]
	Insured	[X]	[X]
	Overseas	[X]	[X]
	<b>Total</b>	[X]	[X]

Source: CC analysis.

Note: These estimates are based on FY11 revenue figures, including the split between inpatient, day-case and outpatient treatments and self-pay, insured and overseas patients.

11.222 As set out in Appendix 11.2, we believe that these estimates may be conservative since they do not take into account:

- (a) the most recently-measured difference between HCA and TLC's prices, which was [X] per cent in 2011, rather than the [X] per cent average difference over the 2007 to 2011 period, which we have used in our analysis;<sup>936</sup>
- (b) any potential impact on the prices charged for outpatient procedures, either for insured, self-pay or overseas patients; or

<sup>936</sup> We note that the difference in prices between HCA and TLC as measured by the IPA increased over the 2007 to 2011 period, with an average difference of [X] per cent (which we have used in this analysis) but a difference as of 2011 of [X] per cent.

- (c) any benefit to patients arising from an increase in fulfilled demand from the lower prices charged.

- *Competition and investment in quality improvements and innovation*

11.223 HCA argued that the CC had no evidence that the divestment remedy would be likely to result in increases in quality and/or innovation in the market.<sup>937</sup> HCA argued that the CC had failed to give sufficient consideration to issues of clinical quality in its assessment of AECs and of the impact of a divestiture remedy. We consider in detail in Section 6 competition on quality and innovation in the private healthcare market. We do not reproduce that discussion here but highlight that we found that this market was characterized by firms adopting technology by acquiring it from a supplier rather than developing it themselves. As a result, we reasoned that the ‘profit-extraction effect’, which is stimulated by competition, would be a greater driver of firm behaviour than the ‘escape-competition effect’, which can be undermined by greater competition.<sup>938</sup>

11.224 We noted that the evidence available to us supported this view. In particular, we considered the following examples:

- (a) In our case study on TLC’s Cancer Centre, we showed how TLC invested heavily in radiotherapy to match investments made at the Harley Street Clinic and Bupa Cromwell.<sup>939</sup>
- (b) We set out in our case study on Circle’s entry into Bath the example of new endoscopes being purchased by BMI’s Bath Clinic as a result of requests from consultants to replace the Clinic’s 10- to 13-year-old equipment. The consultants concerned pointed out that both Circle’s new hospital in Bath and the local NHS hospital had modern equipment.<sup>940</sup>
- (c) In our case study on Edinburgh, Spire told us that it had invested in optometry equipment in order to compete better with the Edinburgh Clinic for patients.<sup>941</sup> We also saw Spire in Edinburgh invest in a new modular theatre and CT scanner at its Murrayfield Hospital when it knew that Circle was considering entry into the Edinburgh market.<sup>942</sup>
- (d) HCA told us that it had invested in ‘bedside medication verification’, at a cost of £[REDACTED] million, [REDACTED].

11.225 These examples show that local rivalry stimulates a degree of competition on quality and range and, therefore, we expect that an increase in rivalry resulting from divestiture to a suitable purchaser or purchasers in a relevant area would result in increased competition on quality and range (not just on price) and an improvement in the quality of hospital services over time. We have not sought to quantify this benefit for inclusion in our NPV analysis of the costs and benefits of the divestiture remedy as we do not believe that this benefit is amenable to reliable quantification.<sup>943</sup> However, we consider that the advantages to customers of greater rivalry on quality and innovation are likely to become substantial over time.

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<sup>937</sup> [HCA response to provisional decision on remedies, Annex 2](#), paragraphs 1.15–1.49.

<sup>938</sup> See paragraph 6.405ff on competition on quality and range.

<sup>939</sup> [Provisional findings](#), Appendix 6.3, paragraphs 33–36.

<sup>940</sup> *ibid*, Appendix 6.1, paragraph 47.

<sup>941</sup> *ibid*, Appendix 6.2, paragraph 67.

<sup>942</sup> *ibid*, Appendix 6.2, paragraph 44.

<sup>943</sup> For example, investment in less invasive surgical techniques may reduce recovery times for patients, which represents a clear improvement in quality but cannot easily be quantified or valued for our purposes.

## *Proportionality assessment*

11.226 In order to assess the proportionality of our divestiture package, we have taken into account both price/cost factors and the potential impact on quality and range. In the case of the former, we have quantified the costs and benefits and carried out an NPV calculation, whereas, in the case of the latter, we have conducted a qualitative assessment.

- *Net present value of divestitures*

11.227 We estimated the NPV of each of the divestiture packages. We note that this estimate takes into account only the *price* benefits of divestiture and does not account for any quality and/or innovation benefits that we expect would result from the dynamic process of rivalry between competing hospital operators. As a result, we consider that this analysis is likely to understate materially the overall benefits to customers of our divestiture remedies, ie is a conservative estimate of the net benefits.

11.228 We have made a number of assumptions in estimating the NPV of our divestiture remedies, including:

- (a) The one-off costs of divestiture are approximately £[X] million for HCA, as set out in Table 11.8. We reasoned that the transaction costs would be incurred in the first year, while the reorganization costs would be incurred equally across the first two years following divestiture.
- (b) The ongoing costs of divestiture—associated with a loss of economies of scale—are zero in our base case for all years and £[X] million per year in our downside case.
- (c) Our base case estimate of the price benefits of our divestiture remedy is £[X] million per year. In addition, we have used our upside estimate of the price benefit that may be achieved in the central London market (of £[X] million a year).<sup>944</sup> We thought that the price benefits of divestiture would come through partly in the second year following divestiture and fully from the third year onwards, since we have specified that the insurers should continue to recognize the divested hospitals on the same terms for 18 months following divestiture.
- (d) We took into account the likely impact of our information remedies on the level of prices charged by HCA's central London hospitals and deducted this from our estimate of the NPV of the divestiture remedy. In effect, this assumes that the (price) impact of our information remedy and our divestiture remedies would have effect via the same mechanism of increasing competition in the market. We believed that this was likely to be the case.
- (e) We projected the costs and benefits over a 20-year period, assuming that initial period estimates would provide a suitably conservative estimate of annual benefits and costs averaged over the 20-year period. We thought that this approach was reasonable in light of the expected growth in the size of the London market which would increase the benefits, on the one hand, and the potential for some entry or expansion, either via PPU's or other methods, that could take place over this time period and which would reduce the benefits on the other hand.

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<sup>944</sup> See Appendix 11.2 for full details of our approach to estimating the price benefits of divestitures.



(f) We have used a discount rate of 3.5 per cent, in line with the Treasury Green Book.

11.229 HCA put forward two main objections to the methodology for estimating the NPV of our divestiture remedy as set out in the provisional decision on remedies. First, it argued that the static approach did not take account of the likely impact of the other remedies imposed by the CC. HCA highlighted that the remedies relating to agreements between NHS PPUs and private hospital operators, the restrictions on clinician incentives and the information remedies were all likely to increase the level of competitive constraint in the market reducing the incremental impact of divestiture.

11.230 Second, HCA contended that it was not appropriate to assume an otherwise static market by projecting the costs and benefits of the remedy over 20 years, without taking into account the impact of planned entry and expansion into the market, which HCA stated was significant. In this respect, HCA highlighted the expected entry of London International Hospital, a 150-bed facility specializing in oncology, cardiology and neurology, in 2014, as well as the opening of KIMS in Maidstone (also in 2014), which had a stated intention of competing with London hospitals. It argued that KIMS was likely to increase the competitive constraints on London Bridge in particular.<sup>945</sup> HCA also pointed to additional potential entry by Spire, Ramsay and Nueterra, as well as the likely growth and expansion of NHS PPUs over the next few years. Finally, HCA argued that entry and expansion was likely to be sustained by the expected level of growth in the London market which would be driven by a growing, and ageing, population.

11.231 We agreed with HCA that our remedies on PPUs, clinician incentives and the provision of information were likely to have a positive impact on the level of competitive constraint compared with a situation in which they were not imposed, both in central London and elsewhere in the UK. We consider each of these remedies in turn.

11.232 We reasoned that our remedy on PPUs in central London would only be effective in increasing the level of competitive constraint compared with the current situation in cases where an NHS trust wished to start or significantly develop an NHS PPU in conjunction with a private hospital operator. Where, on the other hand, a PPU already existed and a private operator wished to take it over, this remedy would not serve to increase competition but rather prevent it from being weakened.<sup>946</sup> In the former case, we foresee that the remedy may take effect by preventing an incumbent operator in central London from taking on the management of an NHS PPU and encouraging another operator into the central London market. We agreed that this would reduce the incremental impact of our divestiture remedy but we concluded that there was no robust means of quantifying the likely effect. However, we considered that the potential impact should be taken account of qualitatively in assessing the proportionality of our remedy. We are aware of two central London NHS trusts that are currently in a procurement process for a private hospital operator to run their PPUs (Barts and King's College), although it is unclear when these facilities will open and which specialisms they will offer.<sup>947</sup> As set out in paragraph 11.60, we thought that the level of competitive constraint provided by PPUs might be limited in the case

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<sup>945</sup> [HCA response to provisional decision on remedies, Annex 2](#), paragraphs 1.143–1.147.

<sup>946</sup> We consider that this potential impact of our remedy, ie preventing a weakening of competitive constraints, is very important but we note that our analysis of NPV already assumes that there is no weakening of competitive constraints over the 20-year time horizon. Therefore, we did not think that it would be correct to make allowance for any 'additional' impact of our remedy that related to this role.

<sup>947</sup> Spire told us that, in Greater London, both Stanmore and St George's were also in the process of tendering for a private hospital operator to manage their PPUs. However, these are located outside the central London market and are likely to have a substantially reduced impact on competitive constraints in central London as a result.

where they specialized in a single or a small number of specialisms, as is the case for the Guy's and St Thomas' PPU.

11.233 We next considered the likely impact of our remedy restricting the provision of clinician incentives. We noted that the aim of this remedy was to ensure that competition between private hospitals for patients was carried out on the basis of the quality and price of the healthcare services they offer rather than the value of benefits and inducements paid by hospitals to clinicians to encourage referrals. Given the importance of attracting consultants, and the referrals that they bring, to a hospital facility, we reasoned that the most likely impact of this remedy was to increase investment in the quality of healthcare services provided rather than a reduction in the prices charged to patients. The evidence indicates that, in the absence of incentives, consultants are attracted to hospitals by the quality of equipment, nursing support, administration etc. We did not find any evidence to suggest that consultants were attracted to hospital facilities which offered lower prices to patients. We concluded, therefore, that this remedy was unlikely to have a material impact on the prices charged to patients, although it could be expected to increase investment in the quality of healthcare services.

11.234 In paragraphs 11.586 to 11.587, we highlight the difficulties associated with accurately estimating the potential price impact of our hospital performance (or quality) information remedy, which is largely focused on facilitating patient choice on hospital quality rather than on price. However, we tentatively estimated that the remedy may have an (eventual) impact on price of around 1 per cent. While we thought that there was likely to be a significant delay in achieving this price effect, we reasoned that it would be appropriate to take this into account when estimating the incremental impact of our divestiture remedies. Therefore, we have reduced our estimates of the price benefit of divestitures by £[X] million per year (across all our cases), which is approximately equivalent to 1 per cent of HCA's central London revenues. We have applied this effect partially (50 per cent) from the third year following divestitures and fully from the fourth year in order to reflect our view that this remedy would take time to have effect (in part due to the timetable that we have set out for the publication of hospital quality information).

11.235 Finally, we considered the potential impact of new entry on competitive constraints. As set out in paragraph 11.68(d), we found that central London hospitals were generally not constrained by hospitals located outside central London. While we did not think that this necessarily meant that the opening of KIMS would not have an impact on the incremental effectiveness of our divestiture remedy, we considered that the extent of this impact was highly uncertain and, on the basis of the evidence collected during our investigation, it was likely to be limited.

11.236 We have found that there are substantial barriers to entry and expansion in the central London market, in particular as a result of site availability, and that several of the potential new entrants highlighted by HCA were either not likely to exert an effective competitive constraint on central London operators, or were not likely to enter the market in the foreseeable future.<sup>948</sup> As a result of these barriers to entry, we considered it unlikely that there would be substantial new entry into the central London market in the next two to three years and that entry after that period was uncertain. In addition, we observed that some of the recent examples of entry had been unsuccessful, eg BMI's acquisition of the former St Luke's hospital/Weymouth Street. We considered that the expansion of existing operators was more likely and noted the example of King Edward VII. However, the evidence indicated that

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<sup>948</sup> See Section 6, barriers to entry.

expansion in the market tended to be a slow process, with TLC taking around seven years to develop its cancer centre. As in the case of the PPU remedy, we agreed that entry and/or expansion if it occurred on a reasonable scale would reduce the incremental impact of our divestiture remedy, but we concluded that there was no robust means of quantifying the likely effect. However, we considered that the potential impact should be taken account of qualitatively in assessing the proportionality of our remedy.

11.237 In contrast, we reasoned that growth in the central London market would be likely to increase the total price (or revenue) benefit of our remedy for customers by increasing the total number of patients (and size of the market) benefiting. Our NPV calculation does not take any real growth in market size into account, although we considered that the potential impact should be taken account of qualitatively in assessing the proportionality of our remedy.

11.238 The results of our analysis are set out in Table 11.10. In all scenarios, the price benefits of divestiture outweigh the costs, indicating a positive NPV of our remedy even taking into account the potential loss of economies of scale. Our base case estimate indicates a very significant NPV of the remedy of just under £300 million, while even the downside case, which takes into account £[X] million of lost economies of scale each year, gives an NPV of £117.3 million.

11.239 We thought that our ‘base case’ was conservative as it assumed that there was no impact on the prices charged either to international patients, or to self-pay patients for day-case treatments. In addition, we used the average difference in the price charged to insurers by HCA and TLC rather than the most recent estimate of that difference (ie a difference of [X] per cent rather than [X] per cent). These estimates also do not take into account any benefit to patients arising from an increase in fulfilled demand resulting from the lower prices charged.

TABLE 11.10 NPV associated with proposed divestiture packages

<i>£ million</i>		
<i>Net present value of divestitures</i>		
<i>Downside case</i>	<i>Base case</i>	<i>Upside case</i>
117.3	297.8	473.8

Source: CC analysis.

### *Conclusions on proportionality*

11.240 We took into account the quantifiable potential costs and benefits of our divestiture package. We noted that the NPV of the divestitures was substantial on our base case at just under £300 million, and remained positive even when we took into account potential ongoing losses of economies of scale (£117.3 million). In addition, we noted very significant potential upside in terms of the price benefits to patients as a result of introducing more competition into the London market, with an NPV of up to £474 million in this case.

11.241 We recognized that there were certain potential changes in the structure of the central London healthcare market which could have an impact on the incremental effect of our divestiture remedy. On the one hand, new entry or expansion could reduce the NPV of the remedy. However, we reasoned that the very substantial NPVs estimated, even on the downside case which we consider to be highly conservative, made it unlikely that such changes would reduce the values sufficiently to

undermine the proportionality of the remedy. Furthermore, the expected growth in the size of the central London market will increase the NPV of the remedy above the level of the estimates in Table 11.10.

11.242 We examined the evidence submitted by HCA in relation to the quality of the services offered and the innovation that it had brought to the market. We thought that there was a reasonable level of evidence that HCA provided good-quality and high-acuity services and that it had introduced a range of new treatments into the private market in London. However, we did not think HCA's submissions supported its contention that a competitor would have neither the incentive nor the ability to follow a similar strategy or that HCA itself would be prevented from doing so as a result of our divestiture remedy. Indeed, we thought that increased competition in the market would be likely to stimulate further innovation and quality improvements rather than less. While it is not possible to quantify these benefits, we consider that they are likely to be significant and incremental to the price benefits taken into account in our NPV analysis.

11.243 We concluded, therefore, that our proposed divestiture package for HCA met our criteria for a proportionate remedy in that:

- (a) it would be effective in achieving its legitimate aim, ie the increase in competition in the market for privately-funded healthcare services in central London;
- (b) it is not more onerous than needed to achieve its aim, ie there is no smaller package of divestitures or other (non-structural) remedies that would achieve this same aim;
- (c) it is the least onerous to the extent that there is a choice between several effective measures; and
- (d) it does not produce disadvantages which are disproportionate to the aim since the likely price and quality benefits of requiring HCA to divest two of its hospitals exceed the costs substantially.

#### *Conclusion on divestiture remedy*

11.244 We propose, therefore, that HCA be required to divest either the London Bridge and the Princess Grace or the Wellington Hospital including the PMC to a suitable purchaser or purchasers and that it should inform the CMA which package it intends to divest within 30 days of the commencement of the initial divestiture period.

### ***Review of PPU arrangements with private hospital operators***

#### *Introduction and summary*

11.245 As set out in Section 10 we found that:

- (a) weak competitive constraints faced by private hospitals, including PPUs, in a number of local areas across the UK, including central London, combined with barriers to entry and expansion, lead to higher prices of inpatient treatments as well as of some day-patient and outpatient treatments for self-pay patients in these local areas;

(b) weak competitive constraints faced by HCA in central London, combined with barriers to entry and expansion, lead to higher prices being charged by HCA to PMIs across the range of treatments for insured patients in Central London.<sup>949</sup>

We found that in combination these features give rise to AECs in the markets for hospital services.<sup>950</sup>

11.246 We found that in all local areas, including in central London, a combination of high sunk costs and long lead times associated with developing a private hospital together constituted significant barriers to entry and expansion.

11.247 In our provisional decision on remedies we proposed a remedy which would address the AECs by giving the CMA the power, following a case-by-case review, to prohibit a private hospital operator facing weak competitive constraints in a local area from acquiring the right to operate or manage a PPU in the same local area (Remedy 3). The remedy would be applicable throughout the UK.

11.248 In this section we describe the proposed remedy, as set out in the provisional decision on remedies, and then summarize the responses that we have received from the insurers, private hospital operators, Monitor and the OFT.<sup>951</sup> We then set out our decision on the remedy, together with a discussion of the design considerations that we have taken into account and our conclusions on the likely effectiveness and proportionality of the remedy.

## *PPUs*

11.249 We considered that, because PPUs are generally co-located with the relevant trust's NHS facilities and benefit from their infrastructure and support facilities, partnering with an NHS trust to manage a PPU may offer a low-risk means of market entry for private hospital operators. We also considered that the number of PPUs may increase as a result of the lifting of the cap on the amount of private income a trust could earn in accordance with the [Health and Social Care Act 2012](#).

11.250 However, in our provisional decision on remedies we said that if a private hospital operator, which faced weak competitive constraints in a local area, entered into a partnership or other business agreement with a trust to operate or manage a PPU in the same local area, this would prevent a new entrant from doing so and thereby prevent market concentration in that local area from being reduced. We therefore proposed Remedy 3, which would make it easier for a new entrant to partner with an NHS trust to operate or manage a PPU.

11.251 This market-opening remedy would address the AECs by giving the CMA, following a case-by-case review, the power to prohibit a private hospital operator, facing weak competitive constraints in a local area, from acquiring the right to manage an NHS PPU in the same area. The remedy would be applicable throughout the UK.

11.252 As competitive conditions could change, we considered that it was not appropriate to apply this remedy only to those local areas where at the time of our report we found that private hospital operators faced weak competitive constraints. We also proposed that an outright prohibition from operating a PPU in areas where private hospital

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<sup>949</sup> Paragraph 6.495.

<sup>950</sup> Paragraph 10.5.

<sup>951</sup> These responses have been gathered from written submissions, informal meetings, and formal hearings.

operators face weak competitive constraints would be inappropriate and that instead they should be subjected to scrutiny on a case-by-case basis.

### *How the remedy would address the AEC*

11.253 As set out in our Remedies Notice, this remedy would address barriers to entry by restricting a private hospital operator facing weak competitive constraints in a local area from acquiring the right to manage a local PPU in the same local area. The remedy would therefore increase local rivalry by facilitating market entry to the local area, or market expansion of a smaller existing operator, through a partnership with the NHS trust to operate the PPU.

11.254 While some such arrangements may be subject to review under the merger control regime, we noted that some recent arrangements were not considered to be 'relevant merger situations' as required under Part 3 of the Act (see paragraph 11.297). It is therefore intended that this remedy would complement merger control provisions (UK or EU) and apply only to those arrangements to operate or manage PPUs which were outside the merger regimes.

### *What parties told us*

11.255 We asked parties for their views on the effectiveness of the proposed Remedy 3, as proposed in our provisional decision on remedies, including whether it would be practicable for a hospital operator with no local facilities to operate a PPU on behalf of a Trust, whether the remedy would give rise to unintended consequences, whether customer detriment would arise if, for example, no new entrant appeared and what arrangements for monitoring and enforcement would be necessary.

#### *PMIs*

11.256 Bupa welcomed the proposed Remedy 3 and said that it was necessary and should be put in place immediately following the investigation. However, Bupa raised a number of issues about the design, implementation and impact of the remedy.<sup>952</sup> It said that this remedy must not be restricted in its scope but must cover all private hospital operators, any PPU management arrangements (irrespective of structuring), and the whole of the UK (including central London). It said that the CC must make clear how the competition test would be applied and how it would differ from the SLC test applied in merger control. As there would be no equivalent of a merger second phase, in-depth investigation, Bupa considered that a higher level of confidence would be required than might be typical in a first-phase merger<sup>953</sup> assessment.

11.257 Bupa agreed that a case-by-case analysis was appropriate, and said that such an analysis must establish (a) the dynamics of competition in the local market at the specialism level; (b) the effects on different stakeholder groups (insurers, self-pay, etc); and (c) that any alleged benefits were real, quantifiable and would pass through to consumers. Bupa said that interested parties must be given opportunity to comment on the analysis and, where necessary, input further evidence.<sup>954</sup>

11.258 Bupa said that any alleged relevant customer benefits from the partnership between a local incumbent and the PPU must be proved to a high standard if they were to

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<sup>952</sup> [Bupa response to provisional decision on remedies](#), paragraph 4.3.

<sup>953</sup> *ibid*, paragraphs 4.5 & 4.6.

<sup>954</sup> *ibid*, paragraph 4.6.

outweigh and rebut the clear reduction in local competition. In particular, the CMA should be obliged to involve Monitor in assessing the benefits case advanced by the parties (particularly where alleged benefits are clinical in nature). Bupa said that, critically, the hospital operator must show that the benefits were unique/specific to its proposed partnership with the PPU. If the benefits were achievable through a partnership with another private operator, which caused less negative impact on competition, then those benefits should be excluded from the assessment. A higher transaction price received by the NHS trust should not be counted as a relevant customer benefit, as the incumbent might choose to outbid others precisely because this will protect its existing market power.<sup>955</sup>

11.259 Bupa said that the time available for review of arrangements which arrangements which were not subject to merger control must allow for detailed assessment of the evidence, an opportunity for public consultation, and sufficient time to design and consult on any undertakings from the parties as conditions of approval. It considered that as the CMA would be reaching a final decision in these cases, the timetable should allow for full analysis of the facts and so may need to be longer than the 40 working days allowed in a standard first-phase merger review.<sup>956</sup>

11.260 Bupa strongly disagreed that safe harbour provisions should be included in the remedy, as these would undermine the effectiveness of the remedy and could lead to unintended consequences. Bupa was concerned that safe harbour provisions would allow, and motivate, a local private hospital incumbent to tie itself to the local PPU while the PPU was still in a nascent state (ie in the planning/set-up phase, when activity and value were very low, and the transaction value or an increase of share of supply might appear minimal). Thus the market might remain concentrated, and entry foreclosed, simply because the incumbent acted quickly to nip competition in the bud while still within the safe harbour.<sup>957</sup>

11.261 Bupa said that the remedy could be effective in offering some protection against concentrated markets becoming more concentrated. However, it noted that the remedy relied on PPUs becoming viable competitors, which in many markets was uncertain, and that it may have no positive impact for consumers outside England, as it was unlikely that the NHSs in Scotland, Wales and Northern Ireland would open PPUs.<sup>958</sup>

11.262 AXA PPP supported this remedy.<sup>959</sup> It said that it believed that the remedy would assist to facilitate new entrants to partner with NHS Foundation Trusts to operate PPUs, either completely new entrants to the UK private hospital market or, perhaps more likely, an existing operator that was not already present in the local market in which the PPU operated.<sup>960</sup> AXA PPP said that if set up and run appropriately, PPUs were able to offer some competition to stand-alone private hospitals. It said that PPUs had advantages in terms of their cost base and buying power for consumables and it would expect prices charged to reflect this and thus be competitive against other private provision, providing contestability in Single and Duopoly areas.

11.263 AXA PPP agreed that a case-by-case assessment, rather than an outright prohibition from operating a PPU in local areas where private hospital operators faced weak competitive constraints, was an appropriate approach. This was because questions of market definition and catchment were complex, and competitive conditions in local

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<sup>955</sup> [ibid](#), paragraph 4.6.

<sup>956</sup> [ibid](#), paragraph 4.6.

<sup>957</sup> [ibid](#), paragraph 4.8.

<sup>958</sup> [ibid](#), paragraph 4.11.

<sup>959</sup> [AXA PPP response to Remedies Notice](#).

<sup>960</sup> [AXA PPP response to provisional decision on remedies](#), paragraph 40.



areas changed over time. AXAPPP said that the flexibility of case-by-case assessment would allow the CMA to consider the 'effect' of the proposed arrangement at the time a PPU contract was tendered by an NHS Foundation Trust. AXA PPP believed that this should be an open process, allowing representations from interested parties.<sup>961</sup>

11.264 AXA PPP supported the pre-notification of all PPU arrangements to the CMA for review. Where these arrangements were not reviewed under the merger control regime, AXA PPP said that it was appropriate to apply a 'competition test' equivalent to the SLC merger test (ie a comparison of the prospects for competition with and without the PPU being operated by the relevant supplier). AXA PPP said that if it was clear that the PPU contract would be awarded, and it was simply a question of to which operator, then the OFT/CC's approach to merger control in rail franchise cases was a good guide (ie the counterfactual used was an operator that raised no competition issues or whose issues had been 'cured'). If the evidence from the NHS and potential alternative operators (and other interested parties) was sufficiently compelling that, without the operator in question, there would be no operational PPU at all, then analogies from the merger guidelines would also work flexibly and well in capturing this situation (analogous to failing firm/counterfactual cases).<sup>962</sup> AXA PPP said that the competition test should apply to *all* proposed PPU arrangements and that the introduction of a de minimis exemption from CMA review was inappropriate. The introduction of any contract value threshold, at this stage, would be arbitrary and was likely to be easily circumvented through a creative repositioning of the contract.<sup>963</sup>

11.265 PruHealth agreed that in Single and Duopoly areas incumbents should be prevented from partnership with NHS facilities.<sup>964</sup> It said that this view was based on its exposure to significant cost increases when an incumbent with Duopoly market power had partnered with an NHS PPU.

11.266 Aviva welcomed this remedy to stimulate competition and supported our proposed enforcement mechanism. It said that PPUs currently accounted only for a small portion of its total spend and it was not aware of any immediate plans for PPUs to expand into Single or Duopoly areas.

11.267 WPA said that it was not convinced that the proposed Remedy 3 would be particularly effective in changing the practices of those providers which were abusing market power. It said that hospital operators which were currently making excessive profits would continue to use their market power to ensure high prices in any new PPU contract they took on. However, the ability for them to continue to do this would only be undermined if the CC's other remedies were successful in reducing prices to a fair level.

11.268 Simplyhealth was generally supportive of the proposed Remedy 3 but unable to comment in detail as it was not aware of the location of the Single and Duopoly areas identified by the CC.<sup>965</sup> It thought that Monitor, as the sector regulator, would be the most appropriate body to oversee and enforce the remedy.

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<sup>961</sup> *ibid*, paragraph 41.

<sup>962</sup> *ibid*, paragraph 47.

<sup>963</sup> *ibid*, paragraphs 50 & 51.

<sup>964</sup> [PruHealth response to Remedies Notice](#).

<sup>965</sup> [Simplyhealth response to Remedies Notice](#), p8.



- 11.269 BMI said that the proposed Remedy 3 was unnecessary as the CC's analysis of barriers to entry was insufficiently robust to support the provisional finding that high barriers to entry were a feature of the private healthcare market. BMI said that, without prejudice to this view, it accepted that in principle the remedy would be both effective and proportionate at resolving any AEC that was found to result from high barriers to entry and weak competitive constraints in many local markets. In particular, BMI said that, when compared with the CC's proposed divestment remedy, Remedy 3 would instead be much more effective in achieving the CC's aims. It said that a key advantage of this remedy compared with other remedies involving divestment and interference in contractual freedom was that it focused on barriers to entry and directly addressed the underlying feature that the CC had supposedly identified, rather than just the adverse effects arising from the feature. Further, BMI said that the proposed Remedy 3 would also be far less onerous on hospital operators.
- 11.270 It said that PPU outsourcings were likely to be a source of significant growth and that the introduction of the Health and Social Care Act 2012—raising the cap on revenues that NHS Foundation Trusts could receive from private patient activity—could be expected only to increase the number of PPUs in coming years. It noted specifically that of the country's 146 Foundation Trusts—each of which had a significant degree of financial autonomy—40 planned to open PPUs.<sup>966</sup> BMI said that PPUs were an excellent opportunity for a new entrant to establish a competitive presence in a local market, particularly in their ability to allow the hospital operator to enter on a scale to meet local demand, making it attractive to form a PPU partnership in an area in which a hospital operator did not already operate a hospital. BMI said that they had a number of other key advantages over new-build facilities. They required a lower capital outlay since they were co-located with an NHS trust (or an NHS Foundation Trust) hospital and benefited from access to pre-existing infrastructure. This reduced the amount of sunk and fixed costs a private hospital operator had to invest in order to establish a presence in a market. BMI said that PPUs also found it easier to attract consultants who benefited from the convenience of their location, usually on the same site as their NHS base, and to the availability close by of the NHS hospital's acute medical facilities. BMI told us that it had considered the feasibility of taking over a PPU on a large number of occasions, overwhelmingly in local areas where it did not already operate a hospital. It also said that it had recently been unsuccessful in tendering for a PPU at the University of South Manchester NHS Foundation Trust, which was 12 minutes' drive from its Alexandra hospital.<sup>967</sup>
- 11.271 BMI listed a number of legal issues which it said the CC would need to consider carefully before it adopted the remedy in the form set out in the Remedies Notice:
- (a) whether intervention was compliant with EU procurement rules that applied to the selection of partners by Trusts;
  - (b) whether the remedy would be more effective and proportionate if PPU tenders were brought within the existing merger control regime; and
  - (c) whether it would be advisable to issue a statement to the effect that it considered a PPU outsourcing contract where the Trust agreed to contribute any private

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<sup>966</sup> Information obtained under the Freedom of Information Act 2000 by Gareth Thomas MP (Lab Harrow West) and reported in *The Guardian* in April 2013 (see [www.theguardian.com/society/2013/apr/06/nhs-hospitals-increase-private-patients?view=mobile](http://www.theguardian.com/society/2013/apr/06/nhs-hospitals-increase-private-patients?view=mobile)).

<sup>967</sup> BMI told us that the Trust did not wish to proceed with a local provider (ie BMI) [§]. In the event, HCA won the contract.

revenues that it currently generated to the PPU to constitute an ‘enterprise’ within section 23 of the Act.

- 11.272 BMI said that the restriction should apply only to the first procurement that an NHS trust (or Foundation Trust) ran. Where that first procurement was unsuccessful, for example if there were no compliant tenders, the trust should be permitted to run the tender in an unrestricted way, whereby the incumbent hospital operator would be permitted to bid for the contract. This was on the basis that if the only way to secure the required investment, development of facilities and expansion of services, as well as income stream for the NHS, in a local area was to allow the incumbent to partner the NHS, then it would be perverse for patients to be denied the benefit of such investment.
- 11.273 BMI raised a number of points on the implementation and monitoring of the remedy. It considered it extremely important that all PPU arrangements be pre-notified. This was because some PPU opportunities would not be advertised in the *Official Journal of the European Union* if they were structured in a particular way (eg a pilot, [X]) and publishing proposed PPU arrangements would ensure that this area was as transparent as possible. BMI also considered it important that the definition of ‘PPU arrangements’ was sufficiently broad to capture both the outsourcing of an existing PPU and what on the face of it might appear to be a straightforward property transaction between an NHS trust (or Foundation Trust) and a private hospital operator conducted ‘off market’.<sup>968</sup> Finally, BMI said that the remedy would have to be subject to a sunset review given the process of change ongoing as a result of the 2012 Act and that it would be appropriate to undertake this review after a period of three years.
- 11.274 BMI supported the use of a competition test similar to the SLC test, as opposed to the ‘bright line’ test proposed in our provisional decision on remedies. This was because it seemed to BMI that the test enabled all relevant circumstances to be taken into account when making a competitive assessment. However, given the broad way in which PPU arrangements might be structured, and the possibility that a PPU might start as a pilot arrangement and develop at a later stage to a more traditional PPU arrangement, BMI said that any ‘safe harbour’ or de minimis provision should be approached with caution. BMI hoped that the case-by-case approach proposed by the CC would be able to address these potential complications.<sup>969</sup>
- 11.275 BMI said that the CMA should publish time frames for its assessment of PPU arrangements, to ensure that there was clarity of expectation and no undue delay caused to tender processes.<sup>970</sup>
- 11.276 HCA said that a restriction on providers preventing them from entering into partnerships with NHS trusts to build new PPU capacity and/or improve existing PPU facilities could seriously restrict the ability of trusts to seek and develop partnerships with appropriate providers with the right operational skills, experience and expertise and the willingness to invest in these projects.<sup>971</sup> It said that this remedy, far from addressing any AECs, would create new and unintended market distortions by limiting the number of providers who would be able to bid for these partnership opportunities.

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<sup>968</sup> BMI response to provisional decision on remedies, paragraph 5.4.

<sup>969</sup> ibid, paragraphs 5.3–5.5.

<sup>970</sup> ibid, paragraph 5.6.

<sup>971</sup> HCA response to Remedies Notice, Section 8.

11.277 HCA said that NHS trusts were ‘contracting authorities’ within the meaning of EU procurement law and were required to go out to competitive tender when selecting providers to manage and operate their PPUs.<sup>972</sup> It said that the Trusts, as a matter of EU procurement law, were required to select providers on the basis of the most economically advantageous tender. HCA said that EU procurement law prescribed the circumstances in which firms may be excluded from tenders and did not allow NHS trusts to reject bids on competition grounds and a remedy requiring an outright prohibition might thus conflict with European law.

11.278 HCA said that existing competition legislation provided the appropriate framework for the CMA to investigate and decide whether a public/private partnership would restrict competition in a local area, rendering a remedy restricting existing operators from further market growth unnecessary.<sup>973</sup>

11.279 It said that if it was the CC’s case that the competition authorities did not already have sufficient powers under the Act/Competition Act 1998 to review PPU partnerships, they could in principle be provided with the powers to review new PPU transactions. Nevertheless, HCA noted that a remedy along those lines would be more likely to represent a more proportionate means than divestiture of addressing the CC’s concerns.

11.280 Spire told us that there was no basis for any remedy whatsoever because the provisional findings did not establish any AEC to the requisite legal standard. However, leaving aside the lack of evidence to support any remedy, the proposed measure would provide private hospital operators that were not active in a given local area with additional opportunities for entry.

11.281 Spire said that the removal of the private patient cap under the Health and Social Care Act 2012 had led a significant number of NHS trusts to explore opportunities to generate additional private revenues, including through PPUs, and it anticipated that this trend would continue. It said that PPUs had recently opened or were being developed in several of the areas the CC had identified as being of concern.<sup>974</sup> It cited the examples of the Clatterbridge Clinic in the North-West of England; the Addenbrooke’s PPU in Cambridge, which Ramsay had been awarded the contract to operate; the recently announced Royal Derby private patient ward;<sup>975</sup> and the Cornelia Suite at the Poole Hospital.<sup>976</sup>

11.282 It said that, in addition, several NHS trusts, including Southampton City, Stanmore, Wythenshawe, Wrightington, Barts, Guy’s and St Thomas’ and St George’s were engaged in formal procurement processes for commercial development partners, elements of which were for private hospitals.<sup>977</sup>

11.283 Spire said it expected that the trend of NHS facilities seeking to expand their private patient offerings would continue and that there would be significant opportunities for private operators to partner with NHS trusts to operate PPUs in the future. It said that

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<sup>972</sup> *ibid*, paragraph 8.4.

<sup>973</sup> *ibid*, paragraph 8.8.

<sup>974</sup> [Spire response to Remedies Notice](#), paragraph 5.3.

<sup>975</sup> Spire said that this was located 1.8 miles away from the Nuffield Derby hospital which the CC had identified as a Solus hospital.

<sup>976</sup> Spire said that this facility was within the area characterized by the CC as an asymmetric duopoly comprising the Nuffield Bournemouth and the BMI Harbour hospitals.

<sup>977</sup> [Spire response to Remedies Notice](#), paragraph 5.3(e).

private patient income in English NHS hospitals rose by 12 per cent in 2012/13 and was forecast to grow by a further 10 per cent in the next 12 months.<sup>978</sup>

11.284 Spire said that a case-by-case review of potential arrangements was a practicable way of creating additional opportunities for entry by new providers to a given geographic area. An SLC test would have the advantage of enabling all relevant circumstances to be taken into account in the competitive assessment, including the dynamic effect of competition and relevant customer benefits. Spire suggested that the existing merger control regime could be extended to cover all proposed PPU partnerships and arrangements.<sup>979</sup> Spire supported the idea of including in the remedy a 'safe harbour' provision which would relieve from further scrutiny transactions which do not give rise to an increase in the private hospital operator's share of supply of inpatient beds in the relevant area to more than 25 per cent. It said that this safe harbour could be based on traditional market share measures in predefined geographical radii. However, Spire did not support basing a safe harbour on the LOCI measures used in our report. It questioned the theoretical merit of LOCI measures and considered that this would be ineffective, because neither the NHS nor the private operators would have sufficient information to calculate a hospital's LOCI.<sup>980</sup>

11.285 Nuffield was broadly supportive of our proposed remedy,<sup>981</sup> but said that restrictions on incumbents partnering with NHS trusts would prevent new entrants and incumbents from competing on a level playing field.<sup>982</sup> If the only way an operator could offer tertiary services was to partner with the NHS hospital, because it had ICU facilities for example, then the incumbent would be denied this opportunity. It said that in recent years it had seen more higher-acuity procedures undertaken and that in smaller markets a PPU might offer the only feasible environment in which to deliver these services. Prohibiting a partnership with the local Trust would thus constrain an incumbent's ability to respond to market trends.

11.286 It gave the example of its 'Solus' hospital in Plymouth which it said was a relatively small PMI market. A rival seeking ways of entering this market might choose to partner with the local NHS trust: it would be able to offer an environment likely to be attractive to local consultants and would be able to offer higher-acuity services. The doctors concerned might then choose to undertake all of their work at the PPU. In these circumstances Nuffield might exit, thus reinstating the status quo of just one operator.

11.287 Nuffield said that it had considered investing in the development of a Trust's PPU which, once complete, would be partially funded by the sale of its existing hospital which could lead to a reduction in local concentration if the original hospital were to be sold to a new entrant.<sup>983</sup>

11.288 It also noted that while the remedy would address an incumbent's ability to expand in the future, it would not address local market power that had been acquired previously.<sup>984</sup> In addition, it said that hospital operators would consider partnering with

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<sup>978</sup> *ibid*, paragraph 5.4.

<sup>979</sup> [Spire response to provisional decision on remedies](#), paragraph 3.2.

<sup>980</sup> *ibid*, paragraph 3.4.

<sup>981</sup> [Nuffield response to provisional decision on remedies](#), paragraph 5.1.

<sup>982</sup> [Nuffield response to Remedies Notice](#), paragraph 4.1.

<sup>983</sup> *ibid*, paragraph 4.6.

<sup>984</sup> *ibid*, paragraph 4.2.

an NHS trust outside their current areas of operation and cited HCA's partnership with the Christie Hospital in Manchester as an example of this.<sup>985</sup>

11.289 Ramsay said that there was no legal basis for applying this remedy to it.<sup>986</sup> As it had not been identified as one of the hospital operators with market power in negotiations with PMIs, any adverse effects arising in the areas where Ramsay had hospitals and which the CC had classified as Single or Duopoly areas could only be in the self-pay sector. However, it said that the concept of Single and Duopoly areas had been derived from the CC's local markets analysis based on data relating to insured patient flows. Since, on the basis of the CC's patient survey and Ramsay's own data, self-pay patients travelled further for treatment than did insured patients, the CC had understated the size of the catchment areas of the hospitals concerned and hence the degree of competitive constraint they were exposed to. It said that the hospitals identified by the CC in the provisional findings did not have Single or Duopoly status for self-pay purposes when measured in the correct catchment area.

11.290 Ramsay said that it was part of [§]. It said that the constraints that would be imposed by Remedy 3 would be significant because it was aiming to have discussions regarding PPUs in areas provisionally identified by the CC as Single or Duopoly areas.

11.291 Further, Ramsay said that it was unnecessary and inappropriate to apply this remedy to all hospitals. It said that this remedy should only be applied in areas where barriers to entry could reasonably be said to exist, such as central London.<sup>987</sup> It said that partnering with the NHS to launch a PPU in London would surmount some of these barriers to entry and that, in particular, it would be easier to attract consultants to a PPU than to a new full-service hospital because that PPU would be attached to the consultant's existing place of work (ie the NHS hospital).

11.292 Circle said that this remedy would deter new entry, as it was very onerous and disproportionate. It believed that NHS interest in PPU outsourcing was mainly confined to London, and so would do nothing to address the significant local market power of monopoly/duopoly operators outside London.<sup>988</sup> The Ulster Independent Clinic<sup>989</sup> said that it did not believe that the remedy would be effective unless directed at all private hospitals in Single or Duopoly areas, as serious distortions of competition could otherwise arise.

11.293 It said that customer detriment would be likely to arise in such circumstances where no new entrant appeared and the incumbent private hospital was prevented from partnering with an NHS hospital. It said that this would arise if patients were prevented from benefiting from imaging and ICU facilities which tended to be extremely expensive and could often only be financed by an effective partnership between hospital operators and PPUs. It said that this was particularly so in a small economy such as Northern Ireland where patients may not be able to travel to Great Britain, either because of the cost and time involved or because their condition would not allow them to do so.

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<sup>985</sup> *ibid*, paragraph 4.4.

<sup>986</sup> [Ramsay response to Remedies Notice](#), Section 4.

<sup>987</sup> *ibid*, paragraph 4.20.

<sup>988</sup> [Circle response to provisional decision on remedies](#), paragraph 3.1.

<sup>989</sup> [Ulster Independent Clinic response to provisional findings and Remedies Notice](#), paragraph 5.2ff.



## *Regulators*

11.294 Monitor told us that its remit only extended to England so it would not be aware of transactions involving NHS organizations elsewhere in the UK. Moreover, it was possible that a foundation trust could enter into arrangements with a private provider in respect of their PPU without this being reported to Monitor. The extent to which Monitor would be aware of such transactions would depend on the nature of the individual arrangements. Monitor said that currently NHS Foundation Trusts were required to inform Monitor of all transactions with a value greater than 10 per cent of the Trust's assets, income or capital and provide assurance in the form of certification. Where the value of the transaction represented greater than 2 per cent of the Trust's assets, income or capital, a more detailed review was triggered. But arrangements involving a private provider would rarely constitute a substantial portion of a Trust's business and thereby trigger the reporting threshold. Monitor would have limited detailed knowledge of Trust arrangements in this context, which was consistent with the level of autonomy conferred upon Foundation Trusts. In instances where a Trust was entering into arrangements regarding a PPU which were below the reporting threshold, Monitor would be likely to acquire detailed knowledge of the transaction if there was deemed to be some risk to quality, if there was an unusual financing arrangement in place to effect the scheme, or if the arrangement constituted a material part of the Trust's strategy.

## *Assessment*

### *Relationship to merger control rules*

- 11.295 We first considered the extent to which this was necessary in order to address the AECs that we had found since it had been put to us that existing merger control provisions were adequate to meet our concerns.
- 11.296 We concluded that in circumstances where the award of a PPU contract to a private hospital operator constituted a merger situation falling within the jurisdiction of the competition authorities, competition concerns could be adequately addressed under existing merger control regimes. However, we noted that recent arrangements were structured in such a way that they did not constitute a merger situation under the Act.<sup>990</sup>
- 11.297 In the case of the arrangement between HCA and the Guy's and St Thomas' Foundation Trust (GSTFT), the agreement explains that 'GSTFT carried out a competitive tender to select a healthcare provider to develop a dedicated private patients unit within the Cancer Treatment Centre from which the healthcare provider will provide cancer treatment and other services to private patients'. The agreement, however, was effected through the granting to HCA of a lease to part of the Borough Wing with the granting by HCA back to GSTFT of an under lease on part of the property. The OFT decided that this arrangement did not constitute a merger situation under the Act.
- 11.298 We considered BMI's suggestion (paragraph 11.271) that the CMA should, in effect, deem such arrangements to fall within merger control, whether or not they created a merger situation for the purposes of the Act. We concluded that we did not have the powers to do so under sections 159 or 161 of the Act, but that our powers did enable

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<sup>990</sup> Section 79(3) of [the Health and Social Care Act 2012](#) may indicate Parliament's intention to apply merger control to Trusts, but does not appear to extend as far as the arrangements described here.

us to frame a different but appropriate remedy which would address our concerns and have a similar effect.

- 11.299 We concluded that it would be appropriate for us to adopt a remedy to address this aspect of the AECs as the merger regime in Part 3 of the Act would not, in itself, fully address our concerns because arrangements may be structured in such a way that they do not create a relevant merger situation.

#### *Relationship to EU procurement rules*

- 11.300 We next considered the relationship of this remedy to EU procurement rules including the points raised in response to the consultation and in particular whether these rules would limit its effectiveness.
- 11.301 HCA had suggested that this remedy, if it took the form of an outright prohibition rather than a case-by-case review, might fall foul of EU procurement rules which would require NHS trusts to select providers on the basis of the most economically advantageous tender.<sup>991</sup> We therefore considered whether EU procurement law would affect the design of the remedy, for example whether it would, unless modified, prevent us from prohibiting certain private hospital operators from participating in tenders for PPU contracts.
- 11.302 Our view was that EU procurement rules are intended to ensure that public authorities respect the free movement of goods and services, and enter into competitive tenders, leading to best value for money, but that they could not be used to override competition law or merger control, and that NHS trusts would not be required by EU procurement law to make a contract award which gave rise to an AEC (or SLC). Further, as we were now considering a case-by-case evaluation of PPU arrangements, HCA's specific point relating to outright prohibition no longer applied. We therefore concluded that EU procurement law would not prevent this remedy from working in the way that we intend it to.

#### *Implementation*

- 11.303 We next considered how the remedy should be implemented and whether, for example, it would be appropriate to make a recommendation to the Government to amend the Act so as to encompass the kind of arrangements we are discussing here.
- 11.304 We concluded that it would be preferable to adopt a remedy directed specifically at PPU arrangements which were structured in such a way that they did not constitute a merger. We then considered how the remedy could be specified in order to achieve this.

#### *Design considerations and effectiveness*

- *Applicability*

- 11.305 In our provisional decision on remedies, we concluded that, rather than adopting an outright prohibition and specifying areas or types of areas and parties which would be subject to it, as we had proposed in our Remedies Notice, it would be preferable for proposed transactions to be evaluated on a case-by-case basis, on their merits, wherever they arose. The remedy as specified here, therefore, would be applicable

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<sup>991</sup> [HCA response to Remedies Notice](#), paragraph 8.4.

to the whole of the UK and not limited to the areas where we identified competition concerns. It would thus apply to arrangements in any areas where incumbent private hospitals faced weak competitive constraints. In the rest of this section we discuss how the remedy as thus envisaged would work. We first consider the basis on which proposed arrangements should be assessed and then the appropriate body to undertake the evaluation.

- *The basis for evaluation*

11.306 The OFT had initially suggested that a 'bright line'<sup>992</sup> competition test, such as that adopted in Groceries and set out in Schedule 4 of the Controlled Land Order,<sup>993</sup> might be appropriate. The OFT said that the Groceries competition test had worked well, had enabled rapid assessments and had not proved onerous in terms of costs.

11.307 The OFT had suggested that such a test in this case could comprise different stages.

11.308 For example, a first stage could comprise a fascia count of private hospital operators with hospitals within the catchment area of (or isochrone drawn around) the NHS hospital inviting tenders to manage a PPU. In the event that insufficient competitive fascias were present, a second test or filter could be applied, for example a fascia count of private hospital operators within the catchment area(s) of (or isochrones(s) drawn around) any of the hospitals of the private hospital operator considering operating the PPU and located within the NHS hospital catchment area (or isochrone).

11.309 If this indicated competition concerns, then a share of supply test could be applied as a third stage, as in the case of the Groceries competition test, to ascertain the bidder's current share of private healthcare revenue in the local area and the likely effect of it operating the PPU. In this case, for example, the proposed operator might, on the basis of fascia count, appear to face weak competitive constraints but in fact have a low share of supply compared with other operators in an area.

11.310 We recognized that such a test would have the merit of being fairly simple to operate and monitor. However, we noted that, having failed this or any other 'bright line test', the outcome would be a prohibition of the proposed PPU arrangements based upon the criteria that formed the basis of the test and there would be no ability to take any other relevant criteria into account unless express provision was made for that. A simple test such as a fascia count might therefore fail to capture important characteristics of the local market.

11.311 Such a test would also, for example, assess local competitive constraints on private hospital operators differently from the analysis used in the provisional findings and the results of applying could therefore be inconsistent with our findings. A first stage test based on fascia counts and isochrones could, for example, identify competition concerns outside London but would not do so in central London where we found that drive-times are not as important a factor in hospital choice as outside London and that the range of services offered by individual private hospitals can differ significantly. A simple fascia count in central London would not reveal the cause for competition concerns found by our analysis.

11.312 By contrast, we noted that a competition test equivalent to that employed under the merger regime (that is, whether the relevant merger situation is expected to result in

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<sup>992</sup> A straightforward and easy to administer test that would provide unambiguous and consistent results.

<sup>993</sup> Available at: [www.competition-commission.org.uk/assets/competitioncommission/docs/2011/inquirydocs/groceries\\_land\\_order.pdf](http://www.competition-commission.org.uk/assets/competitioncommission/docs/2011/inquirydocs/groceries_land_order.pdf).



an SLC in any market or markets in the UK—the SLC test),<sup>994</sup> while less simple than any bright line test, would have the advantage of enabling all relevant circumstances to be taken into account when making a competitive assessment.

- 11.313 A competition test would assess the extent to which the proposed arrangements for the management of a PPU by a private hospital operator would raise that operator's share in the relevant local area and how this would compare with the counterfactual, that the operator concerned was prevented from operating the PPU. The assessment would take account of actual hospital catchment areas, rather than assuming standard drive-times, and would differentiate between hospitals on the basis of the nature and range of services that they could offer, for example the level of intensive care that they could provide.
- 11.314 We noted that there were other advantages of applying a competition test that was the same or similar to the SLC test. First, the SLC is an established test which is appropriate to assessing the effects of an arrangement that meets the criteria of a relevant merger situation. As such, it would be suitable for assessing the effects of a proposed PPU arrangement. Secondly, it is a test for which there is an existing competition authority with experience of applying the test. Thirdly, there is published guidance available as well as reports of earlier decisions that may be informative about how the relevant body will approach the assessment. Fourthly, as we have noted, some PPU arrangements may be subject to review under the existing merger controls. If a test applicable to any such arrangements that do not fall within such controls is in the same or similar terms, there is added advantage of similar treatment.
- 11.315 In our provisional decision on remedies, we therefore concluded that the competition test that should be applied should be the equivalent of the SLC test. We also decided that, as under the Act, RCBs (as defined by section 134(8) of the Act) should be able to be taken into account before deciding whether the proposal should be prohibited or not. In some cases it may be necessary to obtain appropriate undertakings from the relevant private hospital operator as a condition of giving clearance (see, for example, paragraph 11.335 below).
- 11.316 We received support for this approach from those who responded to our provisional decision on remedies, and there was no support for adopting a 'bright line' competition test instead.
- 11.317 While the competition test would resemble the SLC test, there would be differences in its application. For example, the decision would be taken in all cases without a stage 2 reference being made, and so the provisions in the merger regime relating to circumstances in which a second-stage reference is not made would not apply. There would therefore be a theoretical possibility of different outcomes depending upon whether the competition test or the merger control provisions applied. However, we considered that the likelihood of different outcomes arising is low. In any event, our aim is to design an appropriate test to make a relevant assessment.
- 11.318 As we have noted, the disadvantage of such a competition assessment is that it creates less certainty than a 'bright line' test. We note too that such a test may be more costly to operate. We considered therefore whether it should apply to all proposed PPU arrangements or some only and, if so, what the criteria should be for exemption.

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<sup>994</sup> Section 36 of the Act.

11.319 We considered two ways in which these factors could be addressed. We considered whether it would be appropriate to include in the remedy a 'safe harbour' provision whereby a transaction could be relieved of further scrutiny if it could be shown that it would not give rise to an increase in the private hospital operator's share of supply in the relevant area to more than 25 per cent which is the equivalent threshold in section 23 of the Act. We also considered whether transactions below a certain value could be deemed to be de minimis and, if so, where this level might be set and whether the current threshold for tenders to be advertised under EU procurement rules would be appropriate.

11.320 Bupa and BMI both pointed out that PPU arrangements might start with a pilot scheme or a start-up phase which would not reflect the true size or nature of the proposed arrangements and they therefore considered that a safe harbour or de minimis exception might undermine the effectiveness of the remedy. By contrast, Spire supported a safe harbour exception based on a share of supply of inpatient beds in the relevant area of no more than 25 per cent.

11.321 We took into account the importance of ensuring that our remedy was effective in addressing the AEC. Although notification of these PPU arrangements was voluntary not mandatory, we considered it desirable that parties and their advisers should be clear whether particular arrangements were potentially subject to review, or whether a safe harbour exception applied. It seemed to us that a safe harbour provision would create confusion as to whether the existence of a pilot project or a start-up could create an exemption for the downstream, fully-fledged arrangements of the same project. We also considered that it might be unclear what share of supply of inpatient beds in a particular area a private hospital operator actually enjoyed, because of difficulties in agreeing how the relevant geographic area was to be decided.

11.322 We therefore concluded that there should be no 'safe harbour' or de minimis exception.

#### *Monitoring and enforcement*

- *The appropriate body*

11.323 We next considered which regulatory authority would be best qualified to undertake the competition test, or whether it would be necessary to create a new body to do so. We reasoned that since the competition test that we have decided to adopt would be broadly equivalent to the SLC test applied by the CMA in merger evaluations, and as the CMA would continue to assess PPU arrangements which constituted mergers, it would be the most appropriate body to undertake the competition test we are proposing as the basis for this remedy. However, given its sector expertise and the concurrent powers that it has with the OFT to enforce the provisions of the Competition Act 1998 and make references under the Act, we also considered whether Monitor would be suitable for this role.

11.324 We noted that Monitor has no regulatory responsibilities outside England. Although, currently, health policy in Scotland, Wales and Northern Ireland makes it unlikely that PPUs would be launched there, we could not be sure that this would always be the case. We therefore concluded that Monitor would not be the appropriate body to make the assessment since it could not do so across the whole of the UK.

- *Pre-notification*

11.325 We considered whether it was necessary or appropriate for private hospital operators or NHS foundation trusts contemplating arrangements for the management of a PPU

that would be affected by this remedy to notify the CMA prior to entering into a binding agreement. We noted that the CC had required pre-notification in the context of the 'competition test' arising from its investigation of the groceries market which has some features in common with this remedy, and that AXA PPP had told us that it supported pre-notification of all such PPU arrangements.

11.326 We considered whether pre-notification would be appropriate on the ground that the CMA might not be aware of proposed arrangements.

11.327 We were told that, subject to the value of the contract, a Trust would be obliged under EU Procurement Rules to advertise its invitation to tender in the *Official Journal of the EU*, so we considered that it would be relatively simple for the CMA to maintain awareness of proposals to involve private hospital operators in the management of PPUs.

11.328 On the other hand, Monitor told us that, depending on the particular circumstances, it was possible that a Foundation Trust could enter into arrangements with a private provider in respect of their PPU without this being reported to Monitor. We took into account that our remedy had similarities to the merger regime and that in the UK notification of mergers was voluntary. We noted also that in the merger regime the CMA had power to give notice requiring information to be provided in respect of a completed merger.

11.329 We concluded that, on balance, it was appropriate not to require pre-notification of all PPU arrangements, but that we would enable the CMA to require information from the relevant NHS trust about any PPU arrangements which came to the CMA's attention. We thought that this would keep our remedy consistent with the voluntary nature of the merger regime, while addressing the risk that PPU arrangements which might fail to remedy the AEC would escape review.

- *Timing*

11.330 We considered the representations made by Bupa that, as the remedy would be a 'one-stage' decision, the timetable of a review should allow for full analysis of the facts and so may need to be longer than the 40 working days allowed in a standard first-phase merger review. We accepted that a review should allow for a full analysis of the relevant facts, and that it should be conducted within a reasonable time frame. Nevertheless, we decided that it was not necessary or desirable to prescribe a specific time limit for a review. We considered that there were advantages to the CMA and to the parties to allow the time frame of a review to reflect the particular circumstances of the case, and that in these circumstances an administrative time frame was more appropriate than a prescribed one.

### *Conclusions on effectiveness*

11.331 This is a market-opening measure intended to introduce greater rivalry in areas where existing private hospital operators face inadequate competitive constraints. The remedy will only apply in areas where an NHS trust proposes to enter into arrangements with a private hospital operator in relation to a PPU. This remedy in isolation will therefore not address the AECs comprehensively but should be seen in the context of the package of remedies that we have decided to adopt.

11.332 We next considered whether the remedy was reasonable and proportionate.

## *Proportionality*

11.333 We considered whether this remedy would impose costs on parties and how onerous these were likely to be. We considered that parties would incur the costs of providing information about PPU arrangements to the CMA, either on a voluntary basis or after being given notice, but that, as such PPU arrangements would often also require the parties to make a tender to the relevant NHS trust, the additional costs of providing information to the CMA appeared not to be onerous. In addition, if the CMA decided that the proposed arrangements had to be blocked, the relevant party could at that stage withdraw from the tender process. We thought that there would be costs incurred by the CMA in monitoring the remedy, but that these would be low as the CMA would already carry out a degree of monitoring of the sector, so that the additional cost of monitoring PPU arrangements that would be low.

11.334 We considered that costs to customers could potentially arise from the application of the remedy. For example, if the CMA blocked a proposed arrangement and as a result the proposed PPU would be unable to proceed because there were no alternative candidates to operate it, then consumers in the local area could suffer detriment.

11.335 However, we took into account that we have decided that the remedy should be applied on a case-by-case basis, so that in such circumstances the CMA would be able to take account of all relevant factors as part of its evaluation and would be able to clear the proposed arrangements.<sup>995</sup>

## *Conclusions on proportionality*

11.336 We decided that the remedy would be reasonable and proportionate.

## *Conclusions on review of PPU arrangements*

11.337 We have decided, for the reasons set out here that the remedy would make arrangements between PPUs and private hospital operators to operate or manage a PPU to be subject to the possibility of CMA review. The CMA would prohibit those arrangements found by the CMA not to meet the competition test described above, or in exceptional circumstances take other steps, such as accepting undertakings, as appropriate. We consider that such a remedy would be effective in addressing the AECs and would be proportionate.

## ***Clinician incentives***

### *Introduction*

11.338 In Section 8, we found that one way in which private hospitals compete for referrals is by providing benefits and adopting schemes which encourage clinicians to refer patients to, or treat patients at, their facilities and that these schemes were widespread. We found that such schemes were much more commonly directed at consultants than at GPs.

11.339 We concluded that incentive schemes do affect clinician behaviour, by affecting their referral decisions and by possibly leading to excessive diagnostic tests or consultations.

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<sup>995</sup> In such circumstances we would expect that it would be necessary for the OFT/CMA, in addition, to obtain appropriate undertakings from the hospital operator as a condition of clearance being given.

11.340 In this section, we:

- (a) summarize the aim of the remedy;
- (b) summarize the remedies we considered in our provisional decision on remedies;
- (c) set out the responses to the provisional decision on remedies that we have received from the parties;
- (d) describe what further research we have done, including into the regulation of clinician incentives in the USA, Canada and Australia;<sup>996</sup>
- (e) summarize the current regulatory environment in the UK; and
- (f) set out our decision on remedies to address the AEC arising from clinician incentives.<sup>997</sup>

### *Aim of remedy*

11.341 We found (see paragraph 8.168) that the existence of certain benefits and incentive schemes operated by private hospital operators which reward referring clinicians (directly or indirectly) for treating patients at, or commissioning tests from, their facilities are a feature in the provision of privately funded healthcare services by private hospital operators that gives rise to AECs in the markets for the provision of hospital services by private hospitals. The aim of this remedy is to address the AECs by removing inappropriate incentives on clinicians, either by prohibiting certain types of benefits and incentive schemes outright or by placing restrictions on how other types of scheme may operate. This should result in hospital operators competing for patient referrals on the basis of price and quality rather than on the basis of how generously they incentivize clinicians to refer patients to them for tests or treatment. At the same time, we have been mindful of the need to ensure that our remedy does not prohibit certain types of arrangement between clinicians and hospital operators which can have beneficial effects on clinical quality and patient outcomes.

### *Our proposed remedy*

11.342 In our provisional decision on remedies,<sup>998</sup> we proposed that any scheme operated by a private hospital operator, whether contractual or not, which provided an inducement to, or created an obligation on, a clinician to treat or refer patients for tests at its hospital or hospitals should be prohibited outright. We included within this prohibition arrangements which were caveated with an overriding obligation always to act in the patient's best medical interests or to adhere to GMC guidelines on good practice.

11.343 The proposed remedy prohibited direct benefits and inducements but permitted indirect benefits and inducements<sup>999</sup> of low value (subject to a cumulative de minimis limit of £500 a year) and stated that benefits and inducements of higher value (ie anything that exceeded the cumulative £500 a year de minimis limit) should be charged to the clinician at fair market value. We proposed that private hospital oper-

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<sup>996</sup> The main body of this research is in Appendix 11.3.

<sup>997</sup> Although we use the term 'clinician incentives' throughout this section, as that is the term in general use, this should be taken as referring to inducements to clinicians which affect their referral behaviour.

<sup>998</sup> Remedy number 4.

<sup>999</sup> See paragraphs 8.147 & 8.148 for a discussion of what constitutes direct and indirect benefits and inducements.

ators should disclose both lower-value and higher-value services provided to clinicians on their websites and, in the case of higher-value services, the market value that they imputed to each service. We also proposed that, where a clinician provided services to a private hospital in exchange for remuneration (eg as medical director), then the private hospital should disclose on its website the payments made and a summary of the duties performed by each post-holder.

11.344 The proposed remedy also prohibited equity participation schemes between clinicians and private hospital operators unless they met certain conditions. These conditions were:

- (a) the equity stake must be paid for by the clinician upfront and at fair market value;
- (b) where a private hospital operator is involved, then the equity stake of any individual clinician with practising rights at or the ability to commission tests at the facility concerned should be limited to 3 per cent; and
- (c) the acquisition of an equity stake must not be linked to any requirement on the clinician, express or implied, to refer patients to the private hospital or to conduct a minimum percentage of their private practice at that hospital, or to practise at that hospital for a minimum period, or to commit to providing a given level of throughput (in the case of a joint venture concerning a specialized piece of equipment).

11.345 We further proposed that private hospital operators be required to disclose publicly via their websites which, if any, clinicians practising at their hospital owned equity in their facilities (or in equipment within those facilities).

#### *What parties told us*

- *PMIs*
  - *Bupa*

11.346 Bupa said<sup>1000</sup> that it broadly agreed with the CC's proposals, but:

- (a) The disclosure of goods or services which fell under the £500 de minimis threshold must be made within one month and remain publicly available for five years.
- (b) The CC should draw up guidelines by which hospital operators were able to assess fair market value.
- (c) The CC should set up a reporting system through which third parties could report potential breaches of the remedy to the CMA (for example, a dedicated email address or hotline).
- (d) Its position remained that equity holdings in hospitals by clinicians should be prohibited entirely, and it believed such holdings could be in breach of the GMC's *Good Medical Practice* code, which proscribed dealings which may affect a doctor's ability to deal fairly with their patients. It said that if the CC were minded to permit these, then the CC should prohibit outright the offering to clinicians of equity in private hospital parent groups and subsidiaries above the hospital level,

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<sup>1000</sup> [Bupa response to provisional decision on remedies](#), section 5.

drawing on developments in the USA (since such holdings could have a very significant tying effect and consequently distort referral behaviour by clinicians).

- (e) The CC should introduce an outright prohibition in relation to equity in equipment, since such equity holdings were more likely to have a directly disproportionate effect on referral patterns than a holding in a hospital. It said that equity held in equipment was not necessary to support market entry, and it saw no positive reason why this should be allowed.

- *AXA PPP*

11.347 AXA PPP told us<sup>1001</sup> that it agreed with the CC that incentives to doctors harmed competition. It concurred with the CC's view that such incentives led to increased investigation and treatment. It said that the presence of incentives therefore produced consumer detriment.

11.348 AXA PPP said that it had serious concerns that the CC's proposed approach carried a number of compelling risks of circumvention, most notably in relation to 'indirect incentives' including equity ownership. It said that the CC's distinction between direct and indirect incentives was well intentioned in terms of proportionality but was fundamentally misconceived, because a remedy that permitted indirect incentives was ineffective. Any 'safe harbour' attaching to the incentives remedy should be based on considerations other than a distinction between direct and indirect incentives in order to mitigate the risk of wholesale circumvention. It said that safe harbours were inherently risky and quickly became the foundation or ingredients of avoidance strategies. AXA PPP therefore firmly believed that nothing less than a total and unequivocal prohibition of incentives of any kind would remove this problem. It considered that the CC should demand that the source of a doctor's income in private practice came only from the fees they charged to patients. There should be no transfers of value between a private hospital operator and a clinician. It said that the only exceptions to this principle should be employment of a medical practitioner by a private hospital on normal and reasonable terms, and the provision of services connected with the consultant's work such as provision of consulting rooms and secretarial support at fair market prices. It said that rent reviews should be conducted on an aggregate basis by external valuers, with rent rises applied on a uniform basis, and where consultants in good financial standing had a right of first refusal to continue to rent their consulting room the following year. In essence, the hospital should be required to act like a disinterested landlord.

11.349 AXA PPP said that it did not share the view that doctors having financial interests in facilities was for patient benefit. It said that a doctor may be disinclined to whistleblow against malpractice of medical problems in a hospital if, as an investor, he or she stood to lose significant wealth were the hospital to be fined or to lose customers. It said that it had long held the view that, for example, the Circle model was contrary to the interests of private patients. It said that were the CC to allow some exceptions regarding equity ownership, then an additional monetary limit of £5,000 per consultant should also be applied, with the lower of 3 per cent and £5,000 being the operative limit.

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<sup>1001</sup> [AXA PPP response to provisional decision on remedies](#), paragraph 52 et seq.

○ *Aviva*

11.350 Aviva told us<sup>1002</sup> that no one should be offering incentives, in cash or in kind, to encourage referral of patients to or for treatment at a hospital. It said that this should include incentives offered to providers of primary care services as well as consultants. It also believed that consultants should be obliged to inform patients of their options in relation to hospital facilities and, where appropriate, tell the patient why they were proposing a particular hospital.

11.351 It said that a de minimis exemption, eg for a Christmas present, could be acceptable but any such gifts should be recorded somewhere.

11.352 Aviva said that it did not support an absolute prohibition on consultants owning a financial interest in a hospital or a clinic, and that equity participation by consultants could, in limited circumstances, bring benefits. Banning all equity schemes could limit opportunities for innovation and hamper the development of new services or new propositions of the sort that Aviva would like to see, though it thought that the pro-competitive benefit of investments in new experimental treatments, for example, should have to be demonstrated by doctors to PMIs rather than to some third party. Aviva said that it found it difficult to draw the line on which equity schemes should be permitted but believed that gifted equity stakes (as against equity stakes purchased at fair market value for cash) should be prohibited.

11.353 It said that, in addition to the duty to disclose any payments which is imposed on doctors by the GMC, private healthcare providers should face a duty to record and disclose all direct payments made to consultants. Any provider found to have made a payment in breach of this obligation should be liable to a financial penalty.

11.354 Aviva said<sup>1003</sup> that it supported the remedy set out in our provisional decision on remedies and the enforcement mechanism proposed. It said that the CC should make it clear that the remedy applied not only to consultants but also to other sources of referrals such as GPs and occupational health provision. The CC should also define 'hospital' to include very small outpatient treatment facilities that would not necessarily describe themselves as hospitals (since the remedy related to treatment performed by consultants). It suggested defining this in a similar way to how the Care Quality Commission defined the regulated activity of 'Treatment of disease, disorder or injury'.

○ *PruHealth*

11.355 PruHealth said<sup>1004</sup> that it had no objection to consultants investing their own money in healthcare facilities, provided that it was restricted to an equity shareholding of less than 10 per cent. It said that equity shareholding was generally only an issue when its size was sufficient to influence adverse behaviours. In the case of a publicly listed company with a transparent dividend return, one consultant's over-servicing behaviour, with less than 10 per cent shareholding, would have a minimal effect on the company's dividend return to its shareholders. There was a degree of complexity with private or charitable institutions, and dividend schemes based on phantom shares could be formulated, but transparency was essential.

11.356 PruHealth thought that perverse incentives included:

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<sup>1002</sup> [Aviva response to Remedies Notice.](#)

<sup>1003</sup> [Aviva response to provisional decision on remedies.](#)

<sup>1004</sup> [PruHealth response to Remedies Notice.](#) (PruHealth did not provide a further response to the provisional decision on remedies.)



- (a) cash rewards based on the number of admissions or level of cost generated;
- (b) cash incentives to join a particular facility or hospital;
- (c) cash or other incentives to prescribe or utilize specific drugs, appliances or prosthesis; and
- (d) subsidized or free consulting rooms and/or administration services.

It said that these perverse incentives should be banned for all health professionals, including GPs as well as consultants, and the remedy should apply to laboratories, pharmaceutical companies, suppliers of medical consumables and imaging service providers without limit. The GMC should be made responsible for monitoring financial incentives to doctors, and HMRC had a role in ensuring that any declared income from private practice was justified against an expense statement. It said that no private consultant should be generating private income without incurring or explaining their administration and rental expenses.

11.357 PruHealth said that improving diagnostic and procedure coding would enable cases of overservicing or inappropriate utilization of treatments/investigations to be readily identified by both the hospital and the PMI. It favoured anti-kickback legislation and public declaration in a register of all gifts or benefits in kind received over a certain financial value.

- *Hospital operators*
  - *BMI*

11.358 BMI told us<sup>1005</sup> that it disputed the existence of an AEC giving rise to a requirement for this remedy but [§§].

11.359 BMI told us that it was unequivocally supportive of the CC's proposed ban on direct incentives, but thought it should apply not only to private healthcare operators but to all those who provided healthcare goods and services. It also said that the CC should allow a reasonable period for unwinding these arrangements, and put the onus to unwind equally on the private healthcare operator and the clinician or clinicians concerned.

11.360 With regard to indirect incentives, BMI said that it was supportive of having some sort of de minimis figure (which should probably be inflation linked) on a per facility basis, which should similarly apply also in relation to all those who provided healthcare goods and services (ie not just to private healthcare providers). However, BMI noted that there were certain costs expended on behalf of consultant which would exceed the £500 figure proposed in our provisional decision on remedies. These included production of consultant directories detailing consultants with practising privileges at different facilities, and the costs of non-optional insurance cover for providers (including their staff and consultants) providing services to NHS patients. BMI said that the CC should specify such non-discretionary expenditure as not being an incentive and expressly permitted. BMI said that it supported the CC's proposal that services of higher value (ie in excess of the de minimis limit) should be charged at fair market value and that this should also apply to all those who provided healthcare goods and services (ie not just to private healthcare providers). It said that the obligation to disclose on websites should apply also to the individual clinician(s).

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<sup>1005</sup> BMI response to [provisional decision on remedies](#), Appendix 8.

11.361 In commenting on the CC's proposals with respect to equity participation schemes, BMI said that it was not clear whether the 3 per cent limit applied on a 'per clinician per facility' basis or on a 'per clinician per provider' basis or on a 'per clinician across all private healthcare providers' basis. BMI agreed, however, that equity participation schemes should be subject to rules and said that this should apply also to all those who provided healthcare goods and services (ie not just private healthcare providers). BMI said it also thought the CC should expressly prohibit participation by GPs and other referrers rather than limit their interest to 3 per cent, given GMC guidance. It also said that, if there was to be a limit on equity stakes, then the CC should express it as the beneficial interest itself (rather than simply the equity stake) being limited to 3 per cent, to avoid any trusts being created to benefit a clinician or members of his family. It agreed with the CC's disclosure requirements but said that the disclosure obligation should apply equally to clinicians. It thought that the time period granted by the CC for unwinding or amending existing non-compliant schemes could depend upon whether or not clinicians had been granted their investments for free or explicitly in return for shifting their practice commitments for a given period. It said such schemes were the most likely to be distortive. If fair market value had been paid, it said that schemes should be permitted to run until expiry of the contract, or until the asset was fully depreciated, or for a maximum of three years from the date of the CC's final Order. BMI considered that it would be unfair and disproportionate to require unwinding/amending of investments where consultants had invested in good faith on a commercial basis, given that: (a) such equity participation arrangements were a small part of the UK private healthcare market; (b) the remedy could, in any event, apply on a forward-looking basis immediately; and (c) the existence and extent of any gain to competition and consumers from breaking up existing equity participation arrangements was far from established.

○ *HCA*

11.362 HCA told us that it was important that any remedy which restricted 'incentives' was clear in scope, created legal certainty and applied non-discriminately to all healthcare providers and to PMIs.<sup>1006</sup> It said that there was no logic in excluding consultant-owned facilities from the remedy; if the CC were to apply this remedy only to hospital operators, it would create a new competitive distortion in that hospitals would be restricted in the financial terms which they could offer to consultants, whereas consultant-owned facilities would be under no such restriction.

11.363 HCA agreed with the principle of a de minimis threshold covering the provision of general facilities (tea, coffee, stationery etc) and said that it should suffice for the hospital to make a general statement on its website that it provided facilities of this nature to its consultants. HCA disagreed with the proposal in the provisional decision on remedies that the market value of each service provided should be disclosed on the hospital's website. It said that the precise market value of facilities such as consulting rooms was competitive information and suggested that the principle of transparency would be satisfied by a statement that the value of the services exceeded the de minimis threshold.

11.364 HCA also disagreed with the proposal in the provisional decision on remedies that where a hospital engaged a clinician to provide services, eg as medical director, the hospital should disclose the payments made. It said that this information would normally be regarded as confidential and it would be sufficient transparency for patients if they were aware of the fact that there was a service contract under which

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<sup>1006</sup> [HCA response to Remedies Notice](#), section 9, and [HCA response to provisional decision on remedies](#), section 10.

the consultant was remunerated. It saw no reason to disclose the specific value of the remuneration.

11.365 HCA told us that equity schemes played a valuable role in encouraging new entry and expansion, and hence lowering barriers to entry, by encouraging consultants to innovate and creating new services and ventures. It said that equity schemes which unlocked new investment and encouraged the delivery of new products and clinical services had a pro-competitive impact and many would not come to fruition without consultant engagement.<sup>1007</sup> Equity participation encouraged consultants to be involved in the strategic direction of the new venture and devote their time to developing new services. It said that if the CC intended to limit the equity stake of individual clinicians, the cap should be raised to at least 5 per cent. It said that 5 per cent was often seen as the threshold for non-material shareholdings in corporate transactions and would be too small to influence a consultant's referral behaviour.

11.366 HCA cited examples of where properly structured clinical review procedures could both address the problem of inappropriate referral and the concern that financial involvement might distort best clinical practice.<sup>1008</sup> It suggested prohibiting any express requirement to treat patients at a particular facility, and supported increased transparency of consultant equity participation (eg prominent notices on site or in any documentation issued by the consultant to the patient).

11.367 HCA said that the scale of payments typically made to consultants under equity schemes was unlikely to create a significant incentive effect. The median consultant equity investment in its joint ventures was around £[redacted] and the annual payment to the consultant was £[redacted]. Dividend payments were unrelated to the volume of tests requested or undertaken by the individual clinician and were unlikely to be enough to create an incentive to carry out unnecessary tests.

11.368 HCA said that it fully supported the principle that equity schemes should not have any direct incentive effects by requiring clinicians to bring a designated volume of business to refer minimum numbers of patients to the facility. However, it said that hospitals could legitimately require their consultants to perform a minimum number of procedures in theatre for the purposes of a quality audit and clinical outcomes review. It said that hospitals should be allowed to require consultants to perform the basic minimum number of procedures where this was clearly linked to quality audits as opposed to financial rewards.<sup>1009</sup>

11.369 It said that any remedy should also extend to NHS incentives or restrictions which sought to tie NHS consultants to the NHS trust's PPU. It also said that similar remedies should apply to PMI incentives to consultants which distorted referral patterns and influenced consultant behaviour, such as Bupa's Premier Consultant Partnership Scheme. It said that a remedy would not be fair or proportionate if it applied to hospital operators but not the PMIs.

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<sup>1007</sup> HCA cited examples, including the establishment of a CyberKnife treatment facility at the Harley Street Clinic.

<sup>1008</sup> All clinical referrals to the CyberKnife centre, for example, were screened by a medical director and a clinical research fellow, and then by a multidisciplinary team, the majority of whom were not members of the CyberKnife JV, based on clinical criteria.

<sup>1009</sup> HCA told us that, in relation to its centre in Wilmslow due to open in May 2015, it was requesting that consultants conduct a minimum of [redacted] procedures a month in main theatres to enable it to provide quality and outcome data for both the consultants and the facility. It thought [redacted] procedures would provide a sufficient level of audit data over a period of 12 months but would not be a significant volume requirement on consultants.

○ *Spire*

11.370 Spire agreed<sup>1010</sup> with the general principle that hospital operators should not be permitted to offer economic incentives to consultants solely for the purpose of incentivizing them to refer patients to their facilities. It welcomed the overall approach set out in the provisional decision on remedies and said that a disclosure-based monitoring regime, overseen by an independent regulator, was clearly the most effective and proportionate way of achieving the CC's stated aims.

11.371 Spire proposed a number of amendments to the arrangements set out in the provisional decision on remedies in order to ensure that the remedy was workable in practice (particularly in relation to the administrative demands that it imposed) and sufficiently clear and precise to deliver the level playing field between operators sought by the CC. It said that services which were not benefits to consultants should be expressly excluded from the scope of the remedy, such as services intended to ensure patient well-being and clinical safety (eg training sessions), low-value services provided to consultants on the same basis as to other staff and/or patients (eg parking, food) and services carried out by private hospitals in the ordinary course of their day-to-day business (eg billing activity, GP engagement activity, general hospital promotion events and website support). Disclosure requirements for services of low value should be streamlined (for example, disclosed on the hospital's website as a standard basket available to all consultants) and the de minimis limit should be increased from £500 to £1,500 unless certain 'benefits' were excluded from the scope of the remedy. It said that higher-value services could be disclosed as an itemized list, including the price charged (ie fair market value) together with confirmation that these were available to all consultants with practising rights at the hospital. It also said that the remedy should stipulate that payments to consultants for services provided to a hospital or operator should not exceed fair market value for the service concerned.

11.372 Spire also said that the CC should confirm that genuine 'corporate hospitality', that is both proportionate and not tied to referrals, fell outside the scope of the remedy.

11.373 Spire said that the CC should allow a period of three months from the date of the final Order for implementation of the remedy. It also said that the CC should clarify what was included within the definition of 'clinician' and 'private hospital operator' and provide guidance on how fair market value should be determined. It said that clinicians who were primarily or wholly employed by a private hospital should be excluded from the remedy, and that benefits provided to voluntary participants on medical advisory committees should be excluded provided the value of such benefits was lower than the fair market value of the services provided by participants to the hospital.

○ *Nuffield*

11.374 Nuffield told us<sup>1011</sup> that it supported a complete ban on direct incentives. It said that the introduction of a de minimis limit for services unlikely to sway consultants appeared sensible, and it agreed that higher-value services provided to consultants should be charged at fair market value. It said that it would appreciate clarity around how fair market value might be calculated, for example how should the calculation take account of volume-related discounts or the efficiency savings for hospital operators in offering certain administrative services? Nuffield said that it did not

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<sup>1010</sup> [Spire response to provisional decision on remedies](#), section 4.

<sup>1011</sup> [Nuffield response to provisional decision on remedies](#), section 4.

believe that the list of incentives identified in the provisional decision on remedies was exhaustive, and there was a risk of circumvention.

- *Ramsay*

11.375 Ramsay told us<sup>1012</sup> that it agreed in principle with our proposal to limit the ability of private hospitals to incentivize referrals from clinicians, whether by direct incentives or by equity participation schemes. It said that: (a) it had led the way in the UK in banning direct payments to consultants for referrals; (b) it did not make financial payments to consultants to reward referrals; and (c) it did not offer consultants any equity interests. It said that any prohibition of incentive schemes must be simple in order to avoid the risk of gaming.

11.376 Ramsay said that the CC should provide detailed guidance on what constituted ‘fair market value’ and also guidance on how to distinguish between a service to clinicians and a service to the hospital more generally. For example, it thought that the CC should clearly set out what it considered were tasks undertaken by secretaries which were directly and solely related to care provided by the clinician (eg writing medical notes) and those which could be costs incurred by the hospital more generally (eg patient booking). Costs associated with the latter, and with training (where that training was essential to the safe and efficient operation of the hospital) should not be considered to constitute an incentive.

11.377 It said that the £500 de minimis threshold proposed in the provisional decision on remedies was an unnecessary complication and the proposal would lead to unnecessary administrative costs as hospital operators would have to calculate the fair market value of all incentives, even those of low value, in order to ensure that the threshold was not breached. Instead, it thought the CC should publish a schedule of minor benefits that hospitals could offer consultants free of charge and which should not be considered to be incentives for the purposes of the remedy. These should only include basic workplace amenities such as stationery, tea and coffee; in-house training; and general hospital marketing. It said that the remedy would need to be robustly monitored, as there were very subtle ways in which private hospitals and clinicians might attempt to circumvent it (such as by increasing fees paid to consultants for medical services to NHS patients).

11.378 Ramsay said that, in general, it supported the CC’s equity participation scheme remedy as proposed in the provisional decision on remedies. It said that equity schemes (such as the Circle model) were a means of passing a financial advantage to consultants with the direct intention of influencing their clinical decision-making. However, it said that guidance should be provided on how fair market value should be assessed to ensure consistency, and that fair market value at the launch of a hospital might not accurately reflect the real economic value of an equity participation scheme. It also said that the CC should set out detailed guidance on how the remedy would be monitored and enforced.

- *Circle*

11.379 Circle told us<sup>1013</sup> that it broadly agreed with the CC that ‘direct benefits’ (such as cash-for-patient schemes and the provision of consulting rooms and medical secretaries) were presumptively undesirable. It said that these sorts of arrangements were generally bad for competition because they were invariably used by deep-

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<sup>1012</sup> Ramsay response to provisional decision on remedies, section 4.

<sup>1013</sup> Circle response to the provisional decision on remedies, section 2.3.

pocketed incumbents to entrench their market position, thereby enhancing their pricing advantage vis-à-vis the PMIs).

- 11.380 However, Circle said that equity was fundamentally different from other forms of incentives extended to consultants and—for the Circle model at least—had different aims (see paragraphs 8.152 and 8.153). Circle said that it accepted the argument that equity in respect of a single facility or JV settings could function more as a direct incentive and, as a result, might be more problematic. Circle noted that this problem was also apparent in smaller, exclusively clinician-owned practices (eg ophthalmology, dermatology, cardiology). It said that it therefore failed to understand why the CC, in its provisional decision on remedies, had concluded that clinician-owned operators were exempt from the proposed remedy yet all ‘private hospital operators’ (defined arbitrarily, in Circle’s view, as a facility offering inpatient services), regardless of size or market power, were subject to the remedy in equal measure. It said that the competitive harm created by equity ownership appeared to be more pronounced in these smaller sole-ownership settings where the reward for referral behaviour was more directly linked.
- 11.381 Circle said that it did not understand the reasoning behind the CC’s requirement that equity should be paid for upfront, and the CC had not explained in its provisional decision on remedies how this requirement would be applied to options. It saw no compelling reason why consultants should not be eligible to receive options and otherwise participate in a provider’s share scheme on the same basis as all other members.
- 11.382 Circle said that it also failed to understand the requirement for consultants to acquire equity at fair market value. The amount paid for equity did not affect the degree of influence the ownership of such equity would have on a consultant’s referral behaviour. It said that it could only assume that the CC was concerned that consultants would ‘overtreat’ or work for only one provider even in the absence of an obligation to deliver revenues to a facility because they had a financial interest in increasing the value of their equity. Yet both the concern and the condition designed to address it were misplaced with regard to the Circle share scheme.
- 11.383 It also disagreed with the CC’s proposal that equity arrangements with consultants could not be linked to revenue commitments of undertakings to work for a specific period of time at a particular provider, even on a non-exclusive basis. It said that this requirement did not consider how such revenue commitments could be used to enhance competition by lowering barriers to entry or how such benefits outweighed any harmful effects. It told us that revenue commitments in exchange for equity had enabled Circle to attract the necessary financing to build new hospitals. Revenue commitments provided assurance to investors that a critical level of consultants would undertake at least some of their clinical work at the new facility and that without such commitments, Circle would very likely not have been able to finance its new hospitals in Bath and Reading. Circle believed that equity granted based on or as reward for revenue commitments should be permitted in circumstances where it could be shown to encourage competition (eg by attracting investment to build new facilities or make new investment) and was limited in duration (eg the commitment fell away within 24 months of a facility’s opening). Circle also requested the CC to confirm that providers might use equity to reward a clinician’s overall engagement, including taking into consideration the amount of clinical work performed, provided that it was not the sole basis on which the equity was allocated.
- 11.384 By severely proscribing the use of consultant incentives, Circle said, the CC sought to eliminate the influence consultants had on referral behaviour so that operators competed only on price and quality. It said that the problem with this reasoning was



that (a) it assumed that a level playing field would otherwise exist; (b) quality was driven by the clinical engagement that equity ownership encouraged; and (c) operators would not stop competing for consultants. It said that competition for consultants continued to take inventive forms while the CC considered the propriety of past incentives. It said that it was aware of at least one operator which had started to offer consultants enhanced payments for NHS work in an attempt to secure their time for private patient procedures at its facilities.

11.385 Circle said that if the proposed conditions were adopted in their current form, the CC would simply force operators to compete for consultants in different ways, and it was likely that operators would begin to employ consultants directly. In such a scenario, the remedies proposed by the CC would be ineffective, as operators would be able to compensate these employees as they saw fit. This, in turn, would spur an arms race, as operators vied to offer ever more lucrative arrangements with consultants in order to secure their exclusive services and 100 per cent of their patients.

○ *The London Clinic*

11.386 TLC said<sup>1014</sup> that it strongly agreed with the CC's provisional conclusion that incentive schemes operated by private hospitals and equity ownership by consultants of private health facilities affected consultant behaviour and gave rise to harmful effects on competition. It also strongly agreed with the proposal in the provisional findings and Remedies Notice to prohibit hospital operators from offering to consultants any incentives in cash or kind which were 'intended to or had the effect of' encouraging consultants to refer patients to or treat them at its hospitals. It was concerned that the remedy as described in the provisional decision on remedies appeared to have undergone a shift in language and was, as a result, unclear. TLC told us that it would be better to revert to the language of the provisional findings and Remedies Notice which referred to an outright ban on incentives 'intended to or having the effect of' influencing referrals, and that the language of 'direct' and 'indirect' incentives should be dropped.

11.387 TLC told us that if the language of 'direct and indirect' was dropped in favour of a straight prohibition of arrangements intended to or having the effect of influencing referrals, then it would support an exemption for low-value services, subject to disclosure, and an exemption for the provision of higher-value services at fair market value, as proposed.

11.388 Unless all clinician incentives which had the intention or effect of influencing referrals were prohibited, TLC said that the transparency measures proposed in the provisional decision on remedies could worsen the identified AEC by effectively broadcasting to consultants the fees available from certain hospitals and creating an arms race, resulting in the hospital groups with the deepest pockets having a significant advantage in attracting consultants. It said that disclosure of permitted incentives should be made by private hospitals on their respective websites and by the consultant at the point of referral, either by prominent display or by letter/leaflet provided to the patient.

11.389 TLC said that equity participation by consultants should be permitted (if at all) only if the participation fell below a de minimis exemption expressed by reference to value (as well as or instead of the percentage interest). The prohibition should also include anti-avoidance wording, for example addressing stakes held by family members.

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<sup>1014</sup> [TLC response to provisional decision on remedies](#), paragraph 13 et seq.

○ *Kent Institute of Medicine and Surgery Hospital*

11.390 KIMS said it believed that the remedy, as proposed in the Remedies Notice, might inhibit its ability to offer secondary and tertiary services in Kent. It said that many (but not all) of its consultants would be equity partners in KIMS. The share ownership was in three offerings: those clinicians who had given a personal guarantee to the senior lender of KIMS received 'B' shares equating in aggregate to 5 per cent of the issued share capital in both the KIMS OpCo and the KIMS PropCo; those clinicians who made a cash investment to support the establishment of the hospital received 'B' shares equating in aggregate to 3 per cent of the issued share capital in both the KIMS OpCo and the KIMS PropCo; and those clinicians who participated in the set-up risk and development of the project would receive 'C' shares equating in aggregate to 2 per cent of the issued share capital in both the KIMS OpCo and the KIMS PropCo.<sup>1015</sup> KIMS said that if it were unable to retain the 'B' shares already issued to consultants in consideration for their guarantees and/or cash investments it would have to renegotiate with its lenders as this was a requirement for the provision of its financing. It said that the equity arrangements were set up before the CC investigation and were a fundamental building block of the company. If they were broken, this might mean that the hospital could not fulfil its financial covenants. If it were unable to offer the 'C' shares, it would be ignoring the significant contribution of the consultants towards setting up new and complex services and the risk they were taking in moving their practice. The 'C' shares would only be on offer at start-up and not on an ongoing basis. KIMS told us that they would not be related to the value of referrals and would be split equally among all relevant consultants, including those who did not generate revenue but offered a service as a provider (including anaesthetists, pathologists and radiologists). These 'C' shares would be issued at their nominal value (£0.001 per share).

11.391 KIMS said that its equity partnership with consultants lowered the entry barriers and allowed consultants to develop patient care pathways and improve clinical outcomes in a way they could influence and control and was therefore beneficial to competition. All consultants who met the CQC requirements for clinical practitioners were welcome to work at KIMS and would not receive incentives to do so. The equity share was based on cash investment or guarantee and on start-up.

○ *Nueterra*

11.392 Nueterra said<sup>1016</sup> that it supported the CC's intention to ban short-term incentives (eg cash or free office space) to encourage referrals, but that the CC had not sufficiently distinguished between the 'gift' of an equity interest to a consultant in exchange for a binding contract to refer patients to a particular facility, and the cash investment by a consultant into a partnership, to develop and operate a private hospital. It also said that the proposed carve-out for schemes which resulted in a reduction to barriers to entry was vague and difficult to enforce. In Nueterra's view, the CC's proposed remedy (as set out in the Remedies Notice) was disproportionate and insufficiently targeted on the issues of genuine concern. If it was not able to secure the active participation of consultants as a result of the CC imposing remedies in line with those proposed in the Remedies Notice, then Nueterra would be much less likely to invest in the UK.

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<sup>1015</sup> See paragraph 8.97 for a description of financial commitments given by consultants as part of KIMS' fundraising.

<sup>1016</sup> [Nueterra response to Remedies Notice](#). Nueterra did not provide a separate response to the provisional decision on remedies.



- *Aspen*

11.393 Aspen told us that it was concerned that we had grouped long-term equity interests in JVs together with other incentive arrangements which could be said to be aimed more directly at providing benefit to consultants in return for patient referrals or commitments to refer patients. It also did not agree that equity investment was an incentive to commission unnecessary or excessive treatment or that equity models were an indirect financial incentive scheme that drove supernormal profits.

11.394 It said that if only a minority of consultants in a particular specialty in an area entered into an arrangement with a private health provider, there was no evidence that this would prevent entry by another health provider.

11.395 Aspen, which was US-owned, said that it conformed in the UK to the stricter US federal regulations governing illegal remuneration of physicians. It said that experience in the USA had shown that physician-owned healthcare facilities had better healthcare outcomes, shorter stays and significantly higher patient satisfaction ratings than non-physician-owned facilities. Aligning all parties' interests contributed to improved quality of service while driving cost efficiencies and better-value-for-money healthcare. Aspen noted that, in the UK, GPs owned their own premises and the equipment in their surgeries, and consultants sometimes owned their consulting and treatment rooms, day-case surgery facilities and other healthcare facilities including overnight stay facilities.

11.396 Aspen said that, under its model, it retained majority ownership and control of its facilities, and consultants who invested in the equity of a facility were not the only users of that facility. It said that the vast majority of consultants who referred patients to the relevant facilities were not equity investors, and equity investors were not offered preferential terms at the facility. Those who were invited to participate were generally those who were active participants at the relevant facility. Investments were made for cash at fair market value; financial returns were based on the profits of the JV and not on the number of patients referred or treated by the consultant; the arrangement was transparent to patients; and consultants had the ability to sell their equity stake at any time.

- *Others*

- *BMA*

11.397 The BMA told us<sup>1017</sup> that it supported restrictions being placed on clinician incentive schemes that encouraged patients' referrals to particular facilities or for particular treatment or tests. It said that all referrals should be based on the needs of the patient.

11.398 The BMA agreed that services of low value that were listed in the provisional decision on remedies were unlikely to influence consultant behaviour. However, it thought that the proposed £500 de minimis limit was too low to not result in a regulatory burden. It suggested that low-value services should be explicitly defined as part of the remedy, but not be subject to any limit. A statement could then be published on the hospital's website informing patients that all doctors with practising privileges at the hospital had access to these services.

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<sup>1017</sup> [BMA response to provisional decision on remedies](#), section 5.

- 11.399 The BMA also agreed that consulting rooms and secretarial support should be offered equitably to all consultants with practising privileges at a private hospital, rather than allocated selectively. If these services were provided at fair market value, they could not be seen as an inducement. It said that it was therefore unnecessary to publish information on the hospital operator's website about which consultants paid for these services. All that was required was a statement on the website of how much the hospital charged for these services.
- 11.400 It told us that it was not clear how the CC's proposal, that a summary of the duties of doctors who received remuneration for an employed position at a hospital group and information about their salary should be published on the hospital's website, would address any concerns related to referral behaviour or competition in the market. It thought this was disproportionate and recommended that a list of doctors employed by a hospital should appear on the hospital provider's website, accompanied by a disclosure of interests, such as whether they also had practising privileges at the employing hospital.
- 11.401 The BMA agreed that schemes which incentivized doctors to treat or refer private (and NHS waiting list) patients for tests at its hospital or hospitals should be prohibited outright.
- 11.402 The BMA told us that the proposed limit of 3 per cent on equity stakes in a hospital or equipment at which a consultant had practising privileges or the ability to commission tests was too low to encourage consultants to become engaged in the running of a hospital. It said that a minimum stake of 10 per cent was more likely to encourage innovation while still ensuring that the equity stake did not influence referral or commissioning behaviour. It also proposed that the period for unwinding or amending any existing schemes, should they found to be non-compliant, should be 12 months from the date of the CC's final Order rather than six.

### *Approaches to clinician incentives in other jurisdictions*

- 11.403 We considered the laws on physician incentives in the USA, Canada and Australia. The results of this research are set out in Appendix 11.3 and summarized below.

#### *The USA*

- 11.404 In the USA, payments to doctors for referring Medicare or Medicaid patients to particular facilities for inpatient treatment are illegal under the Anti-Kickback Law. This applies to anyone who 'knowingly and willingly offers, pays, solicits or receives remuneration in order to induce business reimbursed under the Medicare or Medicaid programs'. However, prosecutions under the Anti-Kickback Law were rare as the 'knowingly and wilfully' standard was very difficult to satisfy, so the legislation was supplemented by the Stark Acts.
- 11.405 The Stark Acts banned referrals of Medicare and Medicaid patients for clinical laboratory services and certain designated medical procedures where the referring physician has a financial relationship with the laboratory or clinic. Like the 'Anti-Kickback Law', the Stark Acts contain numerous exceptions, including an exemption where the ownership interest of referring physicians is minimal. The 2010 Affordable Care Act (so-called 'Obamacare') tightened the restrictions further, particularly in the case of referrals to hospitals in which the physician owned an equity interest (although pre-existing equity arrangements were grandfathered).

11.406 While there have been many prosecutions under the legislation, a common complaint is that it is complex, riddled with exceptions, and monitoring compliance with it is costly. Because the laws set out very precisely what cannot be done, they also open up loopholes where incentives can be applied. As a result, US regulators regularly issue revised regulations and guidelines to try and close down these loopholes.

#### *Canada*

11.407 In Canada, healthcare is largely publicly funded;<sup>1018</sup> 99 per cent of physician expenditure in Canada comes from public sector sources. Doctors and clinics providing private medical care are not permitted to charge fees any higher than those payable under Medicare unless they are treating non-Medicare-insured persons or providing services which are not available under Medicare. Doctors can refer patients for tests to be carried out in clinics they own or have a financial interest in, and there are no laws prohibiting doctors from owning equity in hospitals or clinics, or from referring patients to hospitals in which they are invested. However, no new private hospitals may be built in Canada, although this restriction does not apply to smaller, specialized medical facilities.

#### *Australia*

11.408 In Australia, approximately 70 per cent of total health expenditure is funded by government. The public system, known as Medicare, typically covers 100 per cent of in-hospital costs, but only a proportion of the cost of seeing a general practitioner and specialist services. The Government subsidizes private health insurance premiums (on a sliding scale according to age and income) and nearly half the population is insured for hospital and/or ancillary benefits. It is a criminal offence to solicit or pay referral fees for admission to a hospital (provided the patient is covered by PMI) or for pathology or diagnostic imaging services. There are restrictions on GP practices leasing space to pathology providers at inflated rents (ie the pathology providers may not provide a financial incentive to doctors through this route) and, since 2010, patients may take test requests to a pathology practitioner of their choice. The direct involvement of consultants in hospital management and ownership is uncommon in Australia but it is permitted and does occur.

### *Regulatory environment in the UK*

#### *General Medical Council*

11.409 The UK regulatory regime applying to doctors and hospitals is set out in Section 2. The conduct of doctors in relation to financial incentives and conflicts of interest is regulated by the GMC.<sup>1019</sup>

11.410 The GMC registers doctors to practise medicine in the UK.<sup>1020</sup> It is overseen by the Professional Standards Authority for Health and Social Care, a statutory body responsible to Parliament and charged with promoting best practice and consistency in professional self-regulation in nine bodies responsible for different branches of the healthcare profession across the whole of the UK.

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<sup>1018</sup> The Canadian public health system is known as Medicare.

<sup>1019</sup> The [Bribery Act 2010](#) may also apply—see paragraphs 11.417–11.420.

<sup>1020</sup> [www.gmc-uk.org/about/index.asp](http://www.gmc-uk.org/about/index.asp).

- 11.411 To treat patients, a doctor must be registered with the GMC and have a licence to practise. Since December 2012, doctors have had to renew their licence periodically through revalidation, the process by which doctors must demonstrate to the GMC that they are up to date and fit to practise.<sup>1021</sup>
- 11.412 The GMC publishes advice to doctors on the standards expected of them. All doctors must follow the advice given in the GMC's *Good Medical Practice*<sup>1022</sup> and its explanatory guidance, which includes advice on avoiding and dealing with conflicts of interest.
- 11.413 The GMC's *Good Medical Practice*, which was updated in April 2013, precludes doctors from accepting any inducement, including financial incentives, that may affect or be seen to affect the way that they treat or refer a patient or commission services—if they have a financial interest in a hospital or clinic to which they plan to refer a patient, this must be disclosed to the patient and recorded in the patient's notes.<sup>1023</sup>
- 11.414 The GMC's *Good Medical Practice* does not have the force of law. However, the GMC does have a range of sanctions that it may apply in the case of serious or persistent failure to follow its guidance: it may issue warnings to doctors, restrict the doctor's registration, suspend (for a period of 12 months) or erase a doctor from the medical register if it finds that a doctor's fitness to practise is impaired. Any such decision by the GMC can be appealed for judicial review.
- 11.415 The GMC does not directly monitor doctors' day-to-day activities, but will act on information or complaints received suggesting that a doctor has failed to act in a way consistent with the principles and standards of good practice set out in its guidance. The GMC told us that it received few complaints about incentives offered to or accepted by doctors or financial conflicts of interest.
- 11.416 The GMC told us that its work was increasingly focused on maintaining and improving standards of education, including the revalidation programme,<sup>1024</sup> which had relevance for all of the 240,000 doctors that were on its register rather than, as in the past, on the 2 to 4 per cent of doctors who were guilty of serious professional misconduct. It told us that, of its approximately 900 staff, 30 were involved in the fitness to practise regime.

### *Bribery Act 2010*

- 11.417 The Bribery Act 2010 (the Bribery Act)<sup>1025</sup> creates a range of new offences relating to corruption which could have application to incentive schemes aimed at doctors. HCA, for example, told us that it had revised the terms of some of its agreements with doctors in order to ensure compliance with the Bribery Act.
- 11.418 The test of whether or not the payment of a referral fee is an offence under the Bribery Act turns on whether or not a reasonable person in the UK would think that

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<sup>1021</sup> [www.gmc-uk.org/doctors/licensing.asp](http://www.gmc-uk.org/doctors/licensing.asp).

<sup>1022</sup> [www.gmc-uk.org/guidance/good\\_medical\\_practice.asp](http://www.gmc-uk.org/guidance/good_medical_practice.asp).

<sup>1023</sup> *Good Medical Practice*, paragraph 78: 'You must not allow any interests you have to affect the way you prescribe for, treat, refer or commission services for patients.' Paragraph 80: 'You must not ask for or accept—from patients, colleagues or others—any inducement, gift or hospitality that may affect or be seen to affect the way you prescribe for, treat or refer patients or commission services for patients. You must not offer these inducements.' The associated guidance notes state, in paragraph 17: 'If you plan to refer a patient for investigation, treatment or care at an organisation in which you have a financial or commercial interest, you must tell the patient about that interest and make a note of this in the patient's medical record.'

<sup>1024</sup> See the GMC's description of this process.

<sup>1025</sup> The Bribery Act applies to all parts of the UK (section 12(1)). Though justice is normally a devolved matter, the Act has been applied to Scotland by means of a legislative consent motion.

such a fee represented an effort to induce performance which was contrary to good faith, partial, or in breach of trust.

11.419 There are two difficulties involved in determining whether or not any particular incentive scheme would be caught by the Bribery Act:

(a) The first is that the Bribery Act is a relatively new piece of legislation and, as a result, there is a paucity of case law concerning it. We have not found any that represents helpful guidance in this instance.

(b) The second is that the Bribery Act employs the perspective of the reasonable person in the UK. As such, this will be a question left to the individual jury.

11.420 It is possible therefore that a jury could find that the provision of referral fees did constitute an offence. In particular, a jury could find that consultants ought to exercise their power of referral impartially and that a referral fee encouraged them to do so partially.

## *Assessment*

11.421 In this section, we first describe the types of incentive schemes that had been adopted by hospital operators and then go on to consider what remedial measures it would be necessary and appropriate to apply to deal with the AEC that we have found.

### *Types of incentive scheme*

11.422 As described in Section 8, we found a very wide range of schemes operated by hospitals which were likely to encourage consultants to treat patients at their facilities. We distinguish here between these on the basis of how closely the schemes link an individual consultant's behaviour to the provision of a reward since we thought this would be informative for our remedies.

- *Incentives and their influence on behaviour*

11.423 We concluded that all incentive schemes provided by hospital operators had the potential to distort competition between providers for referrals but that some were more likely to do so than others. We found, for example, that direct incentives were more likely to do so than indirect incentives and that where rewards are 'pooled', the fewer individuals who share these rewards, the more likely it is that the scheme will affect their conduct. We first discuss direct incentives.

- *Direct incentives*

11.424 We use the term 'direct incentives' to describe schemes or arrangements between hospital operators and clinicians which link, implicitly or explicitly, the value of the rewards provided to a clinician to the value of that individual clinician's conduct to the hospital operator. In other words, there is a linkage between an individual clinician's actions and the value of the rewards he or she receives as a result. Where a clinician could influence the size of his own reward by altering his behaviour, we considered that they would be more likely to do so than if their reward depended on the behaviour of a larger group of clinicians as in schemes where rewards are pooled.

11.425 Some examples of direct incentive schemes that we have found are listed below:

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

○ *Indirect incentives*

11.426 We use the term 'indirect incentives' to refer to schemes or arrangements between a hospital operator and clinicians where there is no linkage between an individual clinician's behaviour and the reward they receive. These might take the form of benefits where no distinction whatsoever is made between the rewards allocated to clinicians, say an event to which all consultants practising at the hospital are invited.

11.427 We would also include within this category schemes adopted by hospital operators which grant or permit clinicians to purchase an equity stake<sup>1026</sup> in a facility to which they refer patients or at which they practise. We have found this to be increasingly common, particularly in the context of new hospital launches, though the practice also extends to circumstances in which a hospital operator effectively 'buys into' a group practice of clinicians.

11.428 Typically in these arrangements, the size of the collective stake owned by clinicians is limited to 49.9 per cent, so the hospital operator always retains control (though some clinician shareholders may be involved in the hospital's management in various ways). In the case of a hospital, an individual clinician's stake is typically low (around 1 to 3 per cent) although in some cases, for example where the JV relates to the ownership of a single piece of high-value equipment, an individual clinician's stake may be higher.<sup>1027</sup> The clinician will be entitled to their pro rata share of dividends,<sup>1028</sup> if any, declared by the hospital (or the company owning/operating the piece of equipment). In arrangements such as this, rewards are, effectively, 'pooled' and shared out irrespective of the clinician's individual contribution to the entity's performance. Clearly, where the pool is small, say just a few clinicians, the scheme's benefits will more closely mimic those offering direct incentives. We return to this issue later.

11.429 The equity stake may be paid for upfront in cash at fair market value, or the hospital operator (as is the case with Circle's original equity scheme) may defer payment for the shares until such time as the shares are sold. Some schemes may allow the clinician to sell the shares at any time for fair market value, while others may only contemplate the clinician selling his shares upon, for example, his death, incapacity,

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<sup>1026</sup> The forms of business entity used for this purpose vary and could include, for example, the establishment of an LLP comprising the hospital operators as a member and a number of doctors.

<sup>1027</sup> In such cases the link between the usage of the piece of equipment concerned and the reward accruing to the doctor will be more direct and may even resemble pay-per-click.

<sup>1028</sup> Or distributions in the case of partnerships.

retirement, moving away from the area, or ceasing to participate in the management of the facility (or ceasing to be members of the JV partnership).<sup>1029</sup> In many (though not all) cases, we found that clinicians with equity shares in a facility also enter into agreements with the hospital operator which oblige them to:

- (a) use their best endeavours to treat patients at the facility concerned or order tests there, subject to the patient's best medical interests and the GMC guidelines; or
- (b) in the case of Circle's agreements, to commit (for a limited period of time) to undertake a certain proportion of their private work, usually around [8] per cent, at the facility.

We also found that the purchase of equity in a facility might, as was the case with KIMS, be associated with or linked to participation in an incentive scheme.

11.430 We considered that it was important to distinguish between these two elements of hospital arrangements with clinicians, ie equity participation and referral obligations, and to understand the relative importance of each in influencing clinician behaviour.

11.431 We found that, although the ownership by a clinician of a small stake in a facility might induce them to refer patients there even if there was an alternative facility of better quality, the existence of a contractual obligation to do so, even if caveated by reference to the best clinical interests of the patient, would be a far more powerful influence (see paragraph 8.161). We therefore considered that agreements by clinicians to commit to using a private hospital operator's facility were more likely to give rise to competition concerns than small-scale share ownership, though we acknowledge that, in practice, the two have been linked.

### *Design considerations*

11.432 In this section, we consider the nature and level of constraints that should be applied to different types of remedy and how the remedy should be designed to achieve these aims. We then conclude on the remedy's effectiveness and proportionality.

11.433 Our AEC finding relates solely to incentive schemes between private hospital operators and clinicians and therefore we do not consider that the remedy should extend to any arrangements which involve only clinicians, or between clinicians and other parties such as insurers, or private healthcare providers other than private hospital operators.

11.434 We considered that the overarching principle should be that any scheme which is intended to encourage, or has the effect of encouraging, clinicians<sup>1030</sup> to refer patients to, or treat patients at, a particular private hospital operators' facilities should not be permitted, and that the duty to avoid entering into such schemes (or to end existing schemes which contravene this principle) should apply to both private hospital operators and clinicians.<sup>1031</sup> For the avoidance of doubt, we considered that

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<sup>1029</sup> [8]

<sup>1030</sup> Clinicians, in the context of this remedy, includes any doctor (eg consultants and GPs) who has the ability to refer patients for treatment or tests at a private hospital. For the avoidance of doubt, it does not include clinicians who are primarily or wholly employed by a private hospital (and who are effectively hospital employees being paid a salary) such as radiologists, resident medical officers and clinicians employed to carry out, for example, Bupa health screening.

<sup>1031</sup> The same overarching principle—and this remedy—applies to a corporate entity which is wholly owned by a clinician, or over which a clinician is able to exercise decisive influence.

all direct benefits<sup>1032</sup> should be prohibited. As far as indirect benefits are concerned, we thought that some could be permitted subject to certain conditions.<sup>1033</sup>

### *Services of low value*

11.435 We began by considering whether there were types of service offered or provided to clinicians the value of which was so low that it would be likely to have no effect on their behaviour and would therefore not constitute an incentive. We considered that if there were, and if the provision of such services could be excluded from our remedy, then the regulatory burden of ensuring compliance on private hospital operators and clinicians could be reduced without lessening the effectiveness of the remedy. In the provisional decision on remedies, we had considered applying a £500 per year de minimis limit, although a number of hospital operators (eg BMI, Spire and Ramsay) told us that the administrative burden on them of determining whether the value of services provided to an individual clinician exceeded this limit could prove to be considerable, and that it would be preferable to list types of low-value service or benefit that we felt would not influence a clinician's behaviour and which could therefore fall outside the scope of this remedy. We also recognized that a de minimis limit could give rise to enforcement problems in ascertaining whether, for example, a service or benefit which it was claimed fell below this threshold did so.

11.436 Spire proposed<sup>1034</sup> that services falling outside the scope of the remedy should include:

- (a) services intended to ensure patient wellbeing and clinical safety (eg in-house training, including basic/advanced life support or infection control, GMC revalidation, the provision of nurse escorts, and the transportation of outpatient notes);
- (b) low-value services that are provided to consultants on the same basis as to other staff and/or patients at the hospital (eg provision of free tea/coffee, parking spaces, subsidized meals in the staff canteen); and
- (c) services carried out by private hospitals in the ordinary course of their day-to-day business activities that also have some incidental impact on consultants working in those hospitals (eg billing activity, GP engagement activity, general hospital promotional events and website support).

11.437 Spire also said<sup>1035</sup> that genuine corporate hospitality provided to clinicians by hospitals that was both proportionate and not tied to referrals should fall outside the scope of the remedy. A similar point was made by BMI<sup>1036</sup> in the context of clinicians who provided services to a private hospital without any financial payment, such as clinicians who acted as members or chairs of Medical Advisory Committees. It said that it provided refreshments at such meetings (which generally took place, because of consultant availability, in the early evenings) and arranged a dinner each year for members (and their partners) by means of a 'thank you'. BMI also gave examples of various other meetings with clinicians which took place at weekends in hotels. It told us that it did not remunerate clinicians for attendance at such events but, in recognition of their time and work, did pay for their accommodation and meals for the

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<sup>1032</sup> This includes not just those types of benefit listed in paragraph 11.425, but also any other arrangement that has a similarly direct link between clinician remuneration and the value of a clinician's actions to a hospital.

<sup>1033</sup> Although not a benefit, we thought that the same principle should apply to privileges such as the allocation of prime theatre slots, ie hospitals should not favour consultants who generated higher levels of referrals when allocating theatre slots.

<sup>1034</sup> [Spire response to the provisional decision on remedies](#), paragraph 4.15.

<sup>1035</sup> *ibid*, paragraph 4.17.

<sup>1036</sup> [BMI response to provisional decision on remedies, Appendix 8](#), paragraph 2.14.



meeting/conference (and travel expenses, where claimed), and would be willing to disclose the market value of such accommodation, dinners etc on its website.

11.438 BMI proposed<sup>1037</sup> excluding from the scope of this remedy two areas of ‘non-discretionary spend’ which it said did not act as an inducement and in circumstances where, if consultants had to pay for these, put private hospitals at a disadvantage when compared with their NHS competitors, where such non-discretionary spend items were at no charge to individual clinicians. BMI said that these areas were the production of consultant directories (detailing the consultants with practising privileges at its various facilities) and the cost of non-optional Clinical Negligence Scheme for Trusts membership or corporate insurance policies which provide cover for providers, their staff and consultants providing services to NHS patients. It said that such cover was a contractual requirement when working with the NHS. Indemnity or insurance cover for consultants’ private practice was a different matter, and should be paid for by consultants themselves.

11.439 Ramsay suggested<sup>1038</sup> that the £500 de minimis threshold was not required and instead we should publish a schedule of minor benefits that hospitals could provide to clinicians which would be deemed to be outside the scope of this remedy. It said that the schedule should only include: incidental expenditure on basic workplace amenities such as stationery, tea and coffee; in-house training, for example on best practice and clinical governance; and general hospital marketing.

11.440 We considered that the general approach to low-value services proposed by Spire, BMI and Ramsay had merit in that it avoided both unnecessary administrative expense by hospital operators in monitoring whether or not the £500 de minimis limit had been breached and the potentially perverse situation where one consultant working at a hospital had to pay for his coffee while another consultant at the same hospital did not. Although the provision of corporate hospitality might not be held to be of low value, we saw merit in treating it in a similar manner to low-value services, subject to certain conditions. We therefore concluded that we did not need to prohibit the provision by private hospitals to clinicians of the following categories of service or benefit:

- (a) services intended to ensure clinical safety, such as appropriate in-house training; services which are an integral part of a facility’s operations, such as patient admission, administration systems and billing where the consultant’s fee is part of a ‘package price’; and insurance or indemnity cover in respect of the treatment of NHS patients;
- (b) basic workplace amenities, such as free tea/coffee, subsidized meals in a staff canteen, stationery and (to the extent they are also available to staff generally and not just to a limited number of senior hospital executives) parking spaces;<sup>1039</sup>
- (c) general marketing of the hospital, including production of consultant directories and general promotional events; and
- (d) corporate hospitality which is proportionate and not tied to referrals and, in the case of, for example, annual dinners for consultants providing unpaid advice, or

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<sup>1037</sup> *ibid*, paragraph 2.11.

<sup>1038</sup> [Ramsay response to provisional decision on remedies](#), paragraph 4.9.

<sup>1039</sup> If the number of parking spaces available at a particular hospital is limited, such that there are insufficient spaces to make parking available to staff generally, then a private hospital can reserve a number of spaces for the use of consultants who are working at the hospital that day, but cannot allocate permanent spaces to named individuals.

offsite conferences, must be disclosed on the facility's website together with the cost of laying on each such event.

11.441 In terms of disclosure of the types of service listed in (a) to (c) above, we concluded that hospital operators should disclose the types of service falling within this exemption that it provided to clinicians generally, but that it was not necessary to disclose the cost of providing each such service or to make a disclosure on a clinician-by-clinician basis. Disclosure should be in place by the date falling six months after the date of our final order.

#### *Services of higher value*

11.442 We next considered goods and services with a higher value (for example, the provision of consulting rooms, secretarial and administrative services, and contributions to professional indemnity insurance in respect of private patients). We concluded that private hospital operators should continue to be able to offer clinicians services of a higher value but subject to certain conditions in order to ensure that the service did not constitute an implicit incentive to refer patients to the hospital(s) concerned.

11.443 Where such goods or services were provided to a clinician by a private hospital group, they should be:

- (a) charged to the clinician at their fair market value;
- (b) made available equitably to all clinicians with practising rights at the facility rather than allocated selectively with preference being given either in terms of allocation or terms on which the good or services were provided, for example to those liable to generate high levels of revenue for the facility operator; and
- (c) disclosed on the private hospital operator's website (by facility) together with the price charged by the hospital operator to clinicians for each service. We did not consider that it was necessary for hospital operators to make a declaration on a clinician-by-clinician basis; rather, it would be sufficient to list the goods and services of this type that the facility offers to clinicians generally, together with the price charged for each good or service.<sup>1040</sup>

11.444 It was put to us by a number of parties that hospital operators would need a little time to introduce the provisions listed above. We decided that it would be reasonable to require full compliance from the date falling six months after the date of our final order.

11.445 In determining the fair market value for each of these services, we considered that hospital operators should be guided by the value for such a service (eg a consulting room) in the locality of the facility, if such a value can be readily determined (including, for example, by consulting an estate agent unconnected with the hospital operator). If such a value cannot be readily determined, then the fair market value should be based on the full cost to the hospital operator of providing the service, including relevant allocated overheads. For example, the cost of providing secretarial services would be based on the cost of employing the secretary together with appropriate allocated overheads such as the cost of providing IT services.

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<sup>1040</sup> HCA told us that, in its view, the precise market value of facilities such as consulting rooms was competitive information and that it should be sufficient for the hospital to disclose that the value of the service exceeded a given threshold (eg £500 a year). We did not agree, and no other hospital operator objected to disclosing the fair market value charged for such services.

11.446 We also thought that, where a clinician provided services to a private hospital in exchange for remuneration, for example by taking up a part-time position,<sup>1041</sup> then the remuneration should be reasonable and proportionate given the nature of the services provided by the clinician (ie fair market value), and the private hospital should disclose on its website the payments made to individual post-holders and a summary of the duties performed by each post-holder on behalf of the private hospital.<sup>1042</sup>

11.447 HCA told us that, in its view, there was no reason to disclose the specific value of the remuneration and that such information would normally be regarded as confidential. HCA thought that there would be sufficient transparency for patients if they were aware of the fact that there was a service contract under which the consultant was remunerated. TLC<sup>1043</sup> thought, however, that consultant referral patterns could be adversely influenced by hospital operators paying significant sums which exceeded the value of services rendered by the consultant to the facility and which in practice had the effect of an incentive payment for referrals. It was concerned that, absent a general prohibition on incentives which had the intention or effect of influencing referrals, our proposed transparency measure could worsen the AEC by effectively broadcasting to consultants the fees available from certain hospitals and creating an ‘arms race’ in which consultants would demand matching or better offers. BMI<sup>1044</sup> was supportive of our transparency proposal, and thought the disclosure obligation should apply equally to all those who provided healthcare goods and services (ie not just private healthcare providers) and to clinicians. We considered that the need to ensure that there was no contravention of the overarching principle that a scheme which is intended to encourage, or has the effect of encouraging, clinicians to refer patients to, or treat patients at, a particular facility should not be permitted, overrode the otherwise understandable concerns about disclosing remuneration details which, in other circumstances, would be treated as private. We also considered that this principle, together with the associated requirement that remuneration should be reasonable and proportionate, meant that the transparency we have proposed would be unlikely to cause an arms race of the type envisaged by TLC.

11.448 Bupa was concerned<sup>1045</sup> that some hospitals may pay disproportionately high and uneconomic rates to consultants for NHS ‘choose-and-book’ procedures in place of the direct financial inducements previously offered for private referrals. Circle raised a similar concern, as did AAGBI.<sup>1046</sup> We considered that such a practice, were it to occur, would contravene the overarching principle that a scheme which is intended to encourage, or has the effect of encouraging, clinicians to refer patients to, or treat patients at, a particular hospital should not be permitted. For the avoidance of doubt, hospital operators are entitled to pay, and consultants are entitled to receive, normal market rates for treating NHS patients in private facilities, but such payments should not be excessive or disproportionate such that they constitute a concealed incentive for private patient referral.

### *Schemes which incentivize patient referrals*

11.449 We next considered what remedies it would be appropriate to apply to schemes operated by private hospitals which are designed to induce, or have the effect of

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<sup>1041</sup> This provision is not intended to cover a situation where a hospital charges a self-pay patient or PMI a packaged fee for a procedure and then reimburses the consultant with their normal fee from the packaged fee. It is also not intended to capture full-time employed clinicians, such as Resident Medical Officers, radiologists, theatre staff or physiotherapists.

<sup>1042</sup> This should not consist merely of the title of the post held by the consultant, for example, but should include a summary list of the duties performed by (or responsibilities of) the consultant consequent upon holding that post.

<sup>1043</sup> [TLC response to provisional decision on remedies](#), paragraph 21.

<sup>1044</sup> [BMI response to provisional decision on remedies](#), Appendix 8, paragraph 2.13.

<sup>1045</sup> [Bupa response to provisional decision on remedies](#), paragraph 5.10.

<sup>1046</sup> [AAGBI response to provisional decision on remedies](#).

inducing, clinicians to refer patients to the scheme operator's facilities, even when subject to various caveats and carve-outs.

11.450 Circle told us that, in its view, the ability to commit consultants for a limited period of time (say, two years) to bringing a minimum percentage of his or her private practice to a newly-opened hospital was essential in order to be able to raise the necessary financing to build that hospital. It said that without such revenue commitments, it would not have been able to finance either Circle Bath or Circle Reading. However, KIMS told us that while consultants' willingness to sign up for a certain number of slots per week/month in advance had been important in giving comfort to its lenders, the banks had not required that consultants specified that they would bring a certain proportion of their work to the hospital, nor did the approach taken by KIMS mean that consultants would face any penalties if they failed to take up the sessions that they had requested.

11.451 We concluded that any scheme operated by a private hospital operator, whether contractual or not, which provided an inducement to, or created an obligation on, a clinician to treat or refer patients for tests at its facilities, should be prohibited outright. For the avoidance of doubt, we would include here arrangements which are caveated with an overriding obligation always to act in the patient's best medical interests or adhere to GMC guidelines on good practice. We considered that such arrangements inevitably create a tension between the clinician's professional obligations to their patient and their financial interest and distinguishing between referral behaviour driven by one or the other would be very difficult in practice. We therefore decided that an outright ban would be the simplest and most effective way of solving the competition problems arising from these arrangements. We did not consider that we should make any exceptions for, say, commitments by consultants to move a proportion of their private practice to a newly-opened facility.

11.452 For the avoidance of doubt, we considered that the ban on inducements to treat at, or refer patients to, a particular facility should apply equally to clinicians as well as hospital operators. In other words, hospital operators should neither offer, nor should clinicians accept, any inducements of the type banned in paragraph 11.451. This means that the duty to end any such schemes which are still in existence falls equally on the hospital operators and the clinicians involved and that no payments should be made by the hospital operators or received by the consultants in order to terminate any existing arrangements. We considered that it would be reasonable to expect all such existing schemes to be unwound within six months from the date of our final Order.

#### *Equity participation schemes*

11.453 We next considered schemes through which clinicians acquired an equity stake in a vehicle or entity created by a hospital operator. We thought that such schemes could, by aligning the interests of the clinician with those of the private hospital operator, create an incentive for clinicians participating in them to treat patients at or to refer patients to the facility concerned for tests.

11.454 We saw several forms of such schemes which were often, though not always, associated with the launch of new private hospitals, for example Circle's hospitals in Bath and Reading, KIMS in Maidstone and the Spire Montefiore hospital in Hove. Other examples of such arrangements not associated with new hospital launches would include various partnerships and JVs that HCA has entered into with groups of consultants, for example the LOC.

- 11.455 We considered whether it would be appropriate to ban such arrangements outright or to prohibit consultants with a financial interest in a private facility operated by a private hospital operator from referring or treating patients there, on the lines of the US legislation. However, private hospital operators, as well as two of the insurers, argued that some of these arrangements were beneficial to competition and to patients. It was put to us that they encouraged consultants to become engaged in the running of the hospital, which could facilitate innovation in treatment and a focus on the quality of care being provided.
- 11.456 Circle in particular said that there was a growing body of evidence that clinical leadership and engagement improved the quality of care. It said that when consultants were given not simply a 'say' in how care was delivered but meaningful operational and decision-making power, it ensured that the care patients received was determined by the individuals best placed to make that determination.
- 11.457 Aviva submitted very similar arguments. It said that it thought equity schemes could be positive because they engaged consultants in decision-making and gave them an interest in ensuring that the hospital delivered the appropriate quality of care to patients. However, Aviva said that where shares were given to a consultant, rather than sold, then first, this beneficial effect would be lessened, and second, there would be a real risk that decisions about patient care would be distorted.
- 11.458 We noted that in the case both of the new private hospital launches and situations where a private hospital operator had bought into a consultant group, the private hospital operators concerned had required clinicians to either enter into an obligation to refer patients to the hospital or had offered them a direct incentive to do so. This indicated to us that the ownership of shares in a hospital per se may not constitute a particularly strong incentive to clinicians to treat patients there since hospital owners had either funded incentive payments to encourage them to do so or sought contractual agreements to oblige them to refer patients to the hospitals concerned. We concluded, therefore, that incentive and referral agreements with clinicians, of the type which we have proposed should be banned, were likely to exert a greater influence on clinicians than equity participation itself, certainly at a low level of shareholding.
- 11.459 We considered, however, that schemes where the pool of rewards was shared between a small number of clinicians, and where an individual clinician's conduct, for example referral or the commissioning of tests, could affect the performance of the business entity, more closely resembled the direct incentive schemes that we provisionally decided should be banned. We concluded that it was important to distinguish between schemes like this, which could give rise to competition concerns, and equity participation arrangements where clinicians have a relatively small share of the business.
- 11.460 We have also in our analysis distinguished between schemes in which a private hospital operator retains a large, and usually a controlling, interest and arrangements which clinicians set up among themselves with no private hospital operator involvement.
- 11.461 We decided that equity participation schemes between private hospital operators and clinicians practising at or referring patients to the hospitals concerned should be allowed, subject to the conditions listed below. The conditions are:

- (a) The equity stake must be paid for by the clinician upfront<sup>1047</sup> and at fair market value. The funding of the purchase by a loan from the private hospital operator, or deferral of payment until the shares are sold, would not be permitted.
- (b) Where a company which owns, directly or indirectly, one or more hospitals is involved (ie the equity participation is a stake in a hospital, or in a JV in which a private hospital operator also has a stake<sup>1048</sup>), then the equity stake of any individual clinician with practising rights at, or the ability to commission tests at, the facility concerned should be limited to 5 per cent. The proposed limit on the size of the shareholding, although larger than the 3 per cent limit we had considered in our provisional decision on remedies, is set at a level where we consider that it is still sufficiently small (and remote) so as to be unlikely to influence the clinician's referral or commissioning behaviour while still providing for an ownership stake to encourage clinician engagement in the setting up and running of the private hospital.<sup>1049</sup>
- (c) The acquisition of an equity stake must not be linked to any requirement on the clinician, express or implied, to refer patients to the private hospital or to conduct a minimum percentage of his private practice at that hospital, or to practise at that hospital for a minimum period, or to commit to providing a given level of throughput in the case of a specialized piece of equipment.
- (d) Any dividends or profit shares distributed to a shareholder must be strictly pro rata to that shareholder's stake in the entity.
- (e) Equity stakes must not be associated with any 'non-compete' restrictions.<sup>1050</sup>

11.462 We considered whether it would be proportionate to require existing schemes (ie where shares or options have been granted to clinicians prior to the date of our final order arising from this investigation) which do not meet these conditions to be unwound (or suitably amended). We concluded that it would be proportionate to require existing schemes to be amended so as to comply with paragraph 11.461(b), (c) and (d) within a period of six months from the date of our final order, but that it would be disproportionate to require such amendment in respect of paragraph 11.461(a) (ie where equity has been granted prior to the date of our final order free or at a discount to its fair market value at the time of grant) as we considered that the incentive effect of granting such equity, for example to induce a clinician to move some or all of their practice to a particular facility, will already have been achieved, and requiring the clinician to pay fair market value retrospectively will not alter the inducement effect.<sup>1051</sup>

11.463 We further concluded that private hospital operators should be required to disclose publicly via their websites which, if any, clinicians practising at their facilities own equity in their facilities (or in equipment within those facilities) and how much (in percentage terms). Hospital operators will also be required to disclose on their web-

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<sup>1047</sup> In the case of options, 'upfront' should be taken to mean at the exercise date, which must not be more than 24 months from the date of grant of the option.

<sup>1048</sup> This would cover, for example, clinics part-owned by clinicians and part-owned by a private hospital group, or individual items of diagnostic equipment or equipment used for treating patients which are part-owned by clinicians and part-owned by a private hospital group.

<sup>1049</sup> The remedy would thus permit a small number of clinicians to own a stake in, for example, an expensive piece of radiotherapy equipment, but each clinician's stake would be limited to 5 per cent.

<sup>1050</sup> For example, restricting a clinician from practising, or providing a similar service to patients, within a certain geographical distance of the facility in which the equity stake is held, or preventing the clinician from owning an equity stake in another competing facility.

<sup>1051</sup> We shall, however, require any new equity participation scheme which is entered into on or after the date of publication of this report, and which does not comply with the conditions set out in paragraph 11.461, to be unwound.

sites what methodology has been employed to determine the fair market value for equity stakes (or equivalent) owned by clinicians. We decided that it would be reasonable to require such disclosure to be in place by the date falling six months after the date of our final order. We also concluded that clinicians should be required to disclose to their patients any equity interest they have in a facility to which they propose to refer the patient, or in any major item of equipment (eg scanner, CyberKnife etc) which they propose to use to conduct tests on or to treat the patient. Such disclosure should be in writing, contained in a letter or leaflet given to the patient.

11.464 A number of parties requested clarification on how fair market value should be determined (given condition (a) in paragraph 11.461) and Circle also sought clarification on how these conditions would apply to its proposal to grant clinicians options over shares rather than shares outright.

11.465 We considered that, where shares are in an entity which is quoted on a recognized stock exchange, then fair market value was easily determined as the closing price of those shares on a particular day. Where a hospital operator grants options over shares, then the exercise price of the option should be the market price of the underlying shares on the date that the option is granted (and the period between the grant date and the exercise date of the option should not be longer than two years). Options must be non-transferable, ie the clinician must not have the ability to sell the option, as transferable options themselves have an option value. The situation becomes more complicated where the shares are in an entity which is not quoted on a recognized stock exchange, such as a private limited company or limited partnership, or are 'virtual shares' in an unincorporated JV (all of which are covered by this remedy). We considered that two methods of determining fair market value would be acceptable in such cases:

- (a) determination of fair market value on an objective, independent basis by a reputable, competent and capable investment bank or accountancy firm, in each case by individuals possessing the requisite expertise; or
- (b) determination by means of a preset formula, published on the hospital operator's website, which values the entity by assigning a reasonable multiple of the prior year's EBITDA or by discounting future cash flows which have been projected on a fair and reasonable basis and using an appropriate discount rate.

11.466 For the avoidance of doubt, this remedy covers all clinicians who have the right to refer patients for treatment or tests at a private healthcare facility (thus including both consultants and GPs but excluding clinicians with no such referral rights) operated by a private hospital operator.<sup>1052</sup> It also covers not only direct ownership interests by a clinician, but also beneficial interests (for example, held through a trust) and indirect interests (for example, interests held by an incorporated entity owned in whole or in part by the clinician) and interests held by members of the clinician's immediate family. Further, the 5 per cent limit on equity participations (see paragraph 11.461(b)) applies per clinician per facility, and not per clinician per provider, or per clinician across all providers.

11.467 We considered whether to impose a limit on equity participations in absolute monetary terms as well as percentage terms. TLC<sup>1053</sup> and AXA PPP<sup>1054</sup> both put it to us that we should, with AXA PPP suggesting that the limit should be set at £5,000. We

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<sup>1052</sup> It does not cover clinicians who are employed by a private hospital under a normal contract of employment.

<sup>1053</sup> [TLC response to provisional decision on remedies](#).

<sup>1054</sup> [AXA PP response to provisional decision on remedies](#), paragraph 65.

considered this carefully, but concluded that it would not be practical to do so, as the value of an equity participation would be likely to vary over time, and also that it was unnecessary; we considered that the key point was that if the clinician's stake was sufficiently small (in percentage terms) and transparent to patients then their individual conduct would be unlikely to have a sufficient impact on the performance of the business entity as to constitute a material incentive to refer or treat patients inappropriately.

### *Oversight*

11.468 The remedy that we have decided to adopt here should not prove complex or expensive to monitor. For the most part, it consists of outright bans on certain forms of conduct, a breach of which would be relatively easy to define. Where not banned, for example the provision of benefits of low value, or higher-value benefits which have to be charged for at fair market value, the transparency provisions that we have proposed should render them open to challenge by interested parties, including competitors and PMIs.

11.469 We envisage that the CMA would have responsibility for ensuring the compliance of the private hospital groups with the remedy. The other candidate that we considered for this role, Monitor, while having considerable expertise in the healthcare sector, has no jurisdiction outside England, whereas the CMA has UK-wide jurisdiction. We also envisage that the CMA will notify the GMC of any incentives which come to its attention which are in breach of the Order and/or which it considers may be incompatible with the GMC's good practice guidelines.

11.470 We also decided that it would be appropriate for the CMA to review this remedy within three years of the date of our final Order in order to establish whether the remedy was working effectively and, if necessary, amend its provisions in order to ensure its continued effectiveness.

### *Conclusions on effectiveness*

11.471 As stated in paragraph 11.423, we concluded that direct incentives were more likely to result in distortions to competition between private healthcare facilities for referrals than indirect incentives. We considered that banning all direct incentives and schemes which provided an inducement to, or created an obligation on, a clinician to treat or refer patients for tests at a particular facility would be effective in addressing part of the AEC that we have found. We further considered that limiting indirect incentives, by making them subject to the conditions set out in paragraphs 11.440 (services of low value), 11.443 (services of higher value) and 11.461 (equity participation schemes), would ensure that the size of any financial incentive on a clinician to make a referral would be sufficiently small, and the reward sufficiently remote, as to make it unlikely to exercise a material influence on an individual clinician's decision on where to refer a patient or what diagnostic tests to order, for example. For this reason, we considered that this remedy would be effective in addressing the remaining part of the AEC that we have found.

### *Proportionality*

11.472 In making our assessment of proportionality, we are guided by the principles set out in paragraph 11.7.



## *Benefits*

- 11.473 The aim of this remedy is to ensure that competition between private hospital operators for patients is carried out on the basis of the quality and price of the healthcare services they offer rather than the value of benefits and inducements paid by hospital operators to clinicians to encourage referrals. As stated in paragraph 11.471, we consider that the remedies that we have set out will be effective in addressing the AEC that we have found.
- 11.474 In addition, we have recognized that certain aspects of the conduct over which we have competition concerns result in customer benefits and sought to maintain these. We have, for example, sought to retain the benefits of consultant engagement associated with equity participation and the positive effect this can have on market entry whilst addressing their potentially negative effects.

## *Costs*

- 11.475 We do not consider that the costs of monitoring this remedy will be significant. For the most part, the remedy consists of an outright ban on certain forms of conduct, breach of which should be fairly easy to identify. Where our remedy falls short of an outright ban, we have accompanied it by transparency requirements which would enable interested parties, including competitors and insurers, to bring potential infringements to the attention of the CMA.
- 11.476 We do not believe that an outright ban on direct incentive schemes will result in any material costs to the parties. The large hospital groups abandoned most cash-based payments to doctors in 2011 and 2012 as the OFT's and later the CC's investigations got under way.
- 11.477 Similarly, in respect of benefits provided to clinicians such as free or discounted consulting rooms and secretarial services, because hospitals will be required to charge a fair market value for them in future, this will reduce rather than increase the costs incurred by private hospital operators, albeit there may be some short-term costs involved in agreeing new terms with clinicians for consulting room licences, for example. Conversely, of course, this proposal will increase the costs to clinicians who have hitherto received such services on a free or subsidized basis, but we considered that these costs were outweighed by the benefit of removing the potential influence on a clinician's referral behaviour. We also considered carefully the argument put to us by a number of parties to the effect that private hospital operators should be able to provide free or discounted consulting rooms for a limited period to consultants who were new to private practice (as some do now), but we were concerned about the potentially distortive effect on referral behaviour of such an inducement and concluded that we should not make an exception for new consultants.
- 11.478 To the extent that cash payments or benefits in kind were intended to encourage referrals, we considered that such payments or benefits would not have been in keeping with the spirit of the GMC good practice guidelines, and so we considered that it would be inappropriate to take account of either the benefits which such schemes conferred on private hospitals (in the form of additional referrals) or the costs to clinicians of forgoing such payments. This remedy is intended to encourage competition between private hospitals on the basis of quality of service, and we considered that it would take only a very small increase in service quality to outweigh the costs to clinicians.
- 11.479 The remaining costs to the parties arising from these remedies will relate to the unwinding of or amendments to equity sharing, joint venture or equivalent arrangements.

These might, for example, require a private hospital group to buy back shares from clinicians so as to reduce their share to the level required. Alternatively, since our restrictions apply to entities jointly owned by private hospitals and clinicians, rather than clinicians alone, the clinicians concerned in these may choose to buy out the private hospital group. Either way, we think that if these transactions take place at fair market value, they will be broadly neutral.

### *Conclusions on proportionality*

11.480 We decided that the remedy we have proposed was proportionate, in that it retained the customer benefits of clinician engagement associated with equity participation and did not impose significant relevant costs on either private hospitals operators or clinicians.

### *Conclusions on clinician incentives*

11.481 We have decided, for the reasons set out here, to:

- (a) prohibit private hospitals from procuring referring clinicians to give preference to their facilities by offering inducements (and prohibit clinicians from accepting inducements to give preference) in the form of low-value direct incentives other than: (i) services intended to ensure clinical safety; (ii) basic workplace amenities; (iii) general marketing of the hospital; and (iv) corporate hospitality which is proportionate and not linked to referrals;
- (b) require private hospital operators to disclose the types of service falling within exemptions (i) to (iii) that it provided to clinicians generally;
- (c) require a private hospital operator providing goods or services of higher value to a clinician to:
  - (i) charge the clinician the fair market value of the goods or services;
  - (ii) allocate the relevant goods or services without giving preference; and
  - (iii) disclose on the private hospital operator's website for the relevant facility each service and the price charged;
- (d) require hospital operators to make such disclosure on their websites within six months of the date of the relevant order;
- (e) prohibit any scheme operated by a private hospital operator, whether contractual or not, which provided an inducement to, or created an obligation on, a clinician to treat or refer patients for tests at its facilities; and
- (f) to place the following conditions on equity participations by doctors in either private hospitals or JVs involving companies which own or operate a private hospital:
  - (i) clinicians must pay the full market value for the stake;
  - (ii) if the equity participation is a stake in a private hospital or JV in which the relevant private hospital also has a stake, the stake of the clinician must be limited to 5 per cent;

- (iii) the equity stake must not be linked to any requirement on the clinician, whether express or implied, to refer patients to the relevant private hospital operator's facilities or conduct a minimum percentage of private practice at that facility or practice at that facility for a minimum period or commit to providing a given level of use of particular equipment; and
- (iv) any dividends or profit shares must be distributed pro rata to shareholders in accordance with their stake.

11.482 Any scheme which does not comply with these conditions must be amended or terminated within six months of the date of the relevant order. The CMA will review this remedy within three years of the date of the relevant order. The CMA will monitor and enforce compliance with this remedy.

## ***Information on consultant and hospital performance***

### ***Introduction***

11.483 In our final report we identified two areas in which insufficient publicly available performance information gave rise to AECs in the provision of privately-funded healthcare services:

- (a) We identified the lack of sufficient publicly available performance (and fee) information on consultants as a conduct feature in the provision of privately funded healthcare by consultants. This feature gives rise to an AEC due to the distortion of competition between consultants by preventing patients from exercising effective choice in selecting the consultants by whom to be diagnosed and treated. This reduces competition between consultants on the basis of quality and price.
- (b) We also identified the lack of sufficient publicly available performance information on private healthcare facilities as a conduct feature in the provision of privately funded healthcare by hospitals. This feature gives rise to an AEC due to the distortion of competition between private healthcare facilities by preventing patients from exercising effective choice in selecting the private hospitals at which to be treated. This reduces competition between private hospital operators on the basis of quality and price.<sup>1055</sup>

11.484 In the provisional decision on remedies, we proposed a single, combined remedy that we considered would address the AEC we provisionally found arising from the lack of information on consultant and hospital performance (Remedies 5-7). In this section, we first summarize the proposed remedy as set out in the provisional decision on remedies and then we provide an overview of the responses to the provisional decision on remedies that we have received from the insurers, the private hospital operators, Private Healthcare Information Network (PHIN) and other interested parties.<sup>1056</sup> Finally, we set out our final decision on the remedy, together with a discussion of the design considerations that we have taken into account and our conclusions on the likely effectiveness and proportionality of the remedy.

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<sup>1055</sup> See Section 10.

<sup>1056</sup> These responses have been gathered from written submissions, informal meetings and formal hearings.

## *Proposed consultant and hospital performance information remedy*

11.485 In the provisional decision on remedies, we proposed that all private hospital operators<sup>1057</sup> with UK turnover of £5 million or more would be required to collect and submit patient episode data for all patients treated at their facilities, whether inpatient, day-case or outpatient,<sup>1058</sup> to a suitable Information Organization (IO)<sup>1059</sup> from which the latter could derive the following types of performance measures at both the hospital and consultant level:

- (a) volumes of procedures undertaken;
- (b) average lengths of stay;
- (c) infection rates, surgical and hospital-acquired;
- (d) readmission rates;
- (e) revision rates (where appropriate);
- (f) information on the frequency of adverse events, such as post-operative DVT and cardiac arrest (where appropriate);
- (g) relevant information from clinical registries and audits as appropriate and where available;
- (h) for the ten highest-volume, or otherwise most relevant, procedures, a procedure-specific measure of improvement in health outcome;<sup>1060</sup> and
- (i) a measure of patient feedback and/or satisfaction on the service provided.

11.486 Furthermore, in the provisional decision on remedies we proposed that, in order to facilitate the analysis and publication of meaningful performance statistics, we would expect the data submitted by the private hospital operators to the information organization to:

- (a) include the GMC number of the consultant responsible for each patient episode occurring in the operators' facilities, since this would allow the IO to derive the same performance measures for consultants as for hospitals;<sup>1061</sup>
- (b) include the NHS number of patients or alternative information from which patients' NHS numbers can be derived;
- (c) contain diagnostic coding<sup>1062</sup> for each episode in order to allow for risk-adjustment where appropriate;

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<sup>1057</sup> This should include all hospitals and clinics providing secondary medical or surgical treatments to patients within the UK, including NHS PPUs and specialist clinics.

<sup>1058</sup> We envisage that this would include all patients receiving treatment of any kind, including diagnostic scans and tests but exclude those attending a facility for a consultation only.

<sup>1059</sup> A suitable organization for these purposes would be one with the ability to design meaningful performance measures in collaboration with industry participants, collect and analyse patient episode statistics and publish outcome measures in a format that is easy for patients to understand according to the timetable set out by the CC.

<sup>1060</sup> The most relevant procedures may not be synonymous with the most common but we would expect a reasonably high level of overlap. A procedure-specific measure of improvement in health outcome might be, for example, the improvement in vision enjoyed by a patient following cataract surgery, or the reduction in pain and increase in mobility following rotator cuff repair surgery.

<sup>1061</sup> All performance measures, whether for hospitals or consultants, can be derived from the same data set. By including the GMC number of the consultant performing the procedure, the hospital operators would thereby ensure that patients would gain access to consultant performance information as well as hospital performance information.

- (d) be fully comparable with that collected by the NHS to allow the information organization to report performance measures for the whole of consultants' practices, both NHS and private, since this is the relevant basis on which to judge performance;
- (e) be made available to the IO in stages, with all the above information submitted by September 2016 to facilitate the publication of these measures over the next three years, with all data made available to the public from April 2017 onwards; and
- (f) be made available with suitable data security provisions in a 'raw' format to all relevant interested parties, including the private hospital operators, consultants, insurers, the CQC, Dr Foster Intelligence and HSCIC from April 2017 onwards.

11.487 We proposed that the private hospital operators be required to provide OPCS coding for all patient episodes.<sup>1063</sup> We noted that the private hospitals currently provided CCSD codes to the insurers for the purposes of billing, and we suggested that, by April 2019, the insurers be required to convert their IT and billing systems to OPCS coding in order to avoid the duplication of effort for the hospitals resulting from the dual-coding of patient episodes.

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

11.489 Finally, we proposed that the CMA should review this remedy five years after our final report to consider whether the information requirements have been met and whether further information is needed by patients to facilitate effective competition.

#### *Information organization*

11.490 We thought that, in order to be effective, a suitable information organization would need to be:

- (a) independent of the private hospital operators, insurers and consultants but be able to work with them, taking their views and legitimate interests into account when reaching decisions on how the information specified by this remedy should be collected, how it should be processed and the format in which it should be published. We suggested that it may be necessary to have CMA-nominated board members to ensure the smooth-running of the organization;
- (b) transparent to all industry participants in terms of its methods and analysis of the data provided by the private hospital operators; and
- (c) funded and resourced to ensure that it has the strategic and technical skills to deliver high-quality performance measures within the timelines set out. We reasoned that the costs of funding the information organization should be met jointly and equally by the private hospital operators and the PMIs in proportion to the number of patients they treat or represent (respectively).

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<sup>1062</sup> An appropriate diagnostic coding system should be an internationally recognized standard such as ICD 10 coding. We would expect the information organization to agree this with the private hospital operators.

<sup>1063</sup> OPCS codes identify the procedure carried out on the patient.

*How this information remedy sought to address the AEC we provisionally found*

11.491 We considered that this information remedy would address the AEC we provisionally found by directly increasing the quantity of information on hospital and consultant performance available to patients, allowing them to make meaningful choices between hospitals and consultants. By making suitable information on hospital and consultant performance available, we reasoned that this remedy should stimulate competition between hospitals and between consultants on the basis of the quality of service they provide to patients driving improvements in the quality of private health-care services in the UK.

*What the parties told us*

11.492 We received a number of detailed submissions on this information remedy. These addressed both the type of information that should be made available to patients and the criteria that an IO would have to meet, in terms of structure and governance, to be considered a suitable body to process and publish this data.

- *PMIs*

11.493 Bupa welcomed the CC's proposed information remedy as providing the necessary steps that the industry must undertake to improve the architecture of information available in the sector and enable better decision-making. Bupa proposed that a few amendments should be made to the information collected and provided to the information organization, including:

- (a) All private hospital operators should be covered by the remedy, ie the £5 million UK turnover threshold should be removed.
- (b) The CC should mandate all consultants to contribute to relevant clinical registries as appropriate and where available in order to ensure that the usefulness of these resources is maximized.
- (c) At least ten procedures should be covered by procedure-specific measures of improvement in health outcomes in order to justify the higher costs consumers face in private (as opposed to NHS) healthcare.
- (d) A standardized template should be used to collect patient feedback and the data should be collected independently rather than by the providers themselves.
- (e) International patients should be assigned a unique identification number (as these patients would not have an NHS number).
- (f) The CC should mandate the use of ICD 10 diagnostic coding on a specified timetable rather than allowing the information organization to agree an appropriate diagnostic coding system with the private hospital operators. In addition, Bupa suggested that PHPs should collect co-morbidity data as part of ICD 10 reporting. Bupa argued that the costs of diagnostic coding should not be funded through the information organization.
- (g) The CC should encourage some of the data to be published by early 2016 given that much of it was already collected by hospital operators.<sup>1064</sup>

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<sup>1064</sup> [Bupa response to provisional decision on remedies](#), paragraphs 6.2–6.20.

11.494 Bupa disagreed that the industry should transition away from CCSD coding and towards OPCS coding and suggested that the remedy should focus instead on extending the scope of CCSD coding to areas which are not currently covered by it, such as drugs, diagnostics and hospital charges, and recommending that the industry commit to investing in and maintaining a complete mapping between CCSD and OPCS coding. Bupa argued that a move away from CCSD coding would (a) undermine the existing payment mechanisms in private healthcare to the detriment of consumers; and (b) impose both transitional and ongoing costs on the industry, which would significantly outweigh the potential benefits.<sup>1065</sup> It argued that OPCS coding was not suitable for processing payments and that it was only used as a basis for such in the NHS in conjunction with ICD 10 coding and patient characteristics. In addition, Bupa highlighted that:

- (a) PMIs would need to run dual-coding systems—at a potential cost of tens of millions of pounds—during a handover period to ensure that experience-rated policies could be accurately priced during the transition.
- (b) OPCS codes did not cover non-procedural activities, such as outpatient appointments, nor did they unbundle elements that were coded and paid for separately in private healthcare, such as consultant time.
- (c) CCSD codes evolved from OPCS codes in response to the differing needs of private providers and insurers, such that a return to OPCS coding would be a retrograde step. Moreover, OPCS coding was controlled/determined by the needs of the NHS rather than the private sector.
- (d) There was, in Bupa's view, a significant risk of disruption to the financial systems of the industry during the switch from one coding system to another, as well as a risk of 'up-coding' during the years immediately following transition as insurers needed to observe patterns of coding over a period before payment integrity rules could be written to identify fraudulent claims.<sup>1066</sup>

11.495 Bupa highlighted several factors that it considered the CC should take into account in specifying how the information organization should work, including:

- (a) Ensuring that board representation on the information organization was balanced between the PHPs, the insurers and patient groups and that the representatives were independent on one another. In particular, Bupa expressed concerns that some of PHIN's current board members, such as the Private Patients' Forum, had close ties with hospital operators. It suggested that consultants should be represented by (a) board member(s) from the Royal Colleges or professional bodies.
- (b) Clarifying the mechanism through which the information organization could sanction market participants who failed to submit data.
- (c) Bupa proposed that the CMA-nominated board members should have a specific role in deciding: the necessary budget for the organization, imposing sanctions on underperforming market participants, arbitrating disputes between the parties, final approval of the body's planned governance and procedures and any subse-

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<sup>1065</sup> Bupa told us that these costs included those of designing and introducing new IT systems, negotiating new contracts under the OPCS codes and managing the impact on customer policies.

<sup>1066</sup> [Bupa response to provisional decision on remedies \(reimbursement coding\)](#), paragraphs 1.1–1.22.

quent minor changes to these, approval of membership, and providing guidance on competition law compliance queries.<sup>1067</sup>

11.496 Finally, Bupa suggested that the information organization should be required to process, analyse and publish the data it received within a specified time frame to ensure that the information published was not outdated and therefore of less use to patients.<sup>1068</sup>

11.497 AXA PPP agreed that there was a lack of information to enable consumer choice but it considered that the provision of such information was problematic, in particular where low volumes of activity resulted in unreliable data. AXA PPP argued that the CC's proposed information remedies were likely to be both costly and ineffective in resolving the problem, noting the considerable expenditure being incurred by the NHS in collecting and analysing such data, as well as the early and developmental stage of these initiatives. It stated that the cardiothoracic data was aimed at identifying outliers to enable further audit rather than creating league tables of performance to allow consumer choice, ie distinctions could only reliably be made at the extremes of the distributions. AXA PPP expressed concern that the volumes of operations undertaken in the private sector would be insufficient to generate reliable statistics.

11.498 AXA PPP argued that OPCS codes were unsuitable for the purposes of PMI reimbursement, were not directly used by the NHS for the purposes of billing, were not updated as frequently as CCSD codes, and that it would be costly to switch from one system to the other. It put forward the view that switching systems would encourage inflation in claims costs as a result of complexity and unbundling. AXA PPP also argued that ICD coding was generally of poor quality, with the large majority of claims that it saw being classified under symptom codes rather than a specific diagnosis. For example, the top three ICD codes in AXA PPP's claims were knee pain, unspecified back ache and shoulder pain.

11.499 AXA PPP proposed that rather than imposing the information remedy as set out in the provisional decision on remedies, the CC should require insurers and hospital operators to work together to look further at the issue of data collection and quality assessment, with a remit to agree what data should be collected for the benefit of consumers in exercising choice.<sup>1069</sup>

11.500 AXA PPP was concerned that PHIN [§] and that it would be biased towards the private hospital operators given its history and links to organisations such as FIPO and the Private Patients' Forum. AXA PPP proposed that a new organization would be needed instead and suggested that better alternatives would be Dr Foster or the NHS Information Centre. It said both Dr Foster and the NHS Information Centre are in a better position to analyse the full patient journey and to ensure consistency with NHS data.

11.501 AXA PPP argued that the remedy set out in the provisional decision on remedies did not require either self-pay patients or the NHS to contribute to funding the information despite comprising a significant proportion of the private healthcare market.

11.502 Aviva strongly supported the CC's proposed remedy on the collection and publication of information on the performance of private hospitals and consultants. However, Aviva expressed concerns that the switch from CCSD to OPCS codes would not be appropriate, citing a lack of suitability of the latter for billing purposes and the costs

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<sup>1067</sup> [Bupa response to provisional decision on remedies](#), paragraph 6.9.

<sup>1068</sup> [ibid](#), paragraph 6.18.

<sup>1069</sup> [AXA PPP response to provisional decision on remedies](#), paragraphs 76–84.



associated with moving from one system to the other. Aviva suggested that it would be preferable to maintain the dual-coding system suggested by the CC as an interim stage.<sup>1070</sup>

11.503 PruHealth noted that any process of risk-adjusting mortality rates to reflect the co-morbidities of patients would be imperfect and that some distortions to reported outcomes might arise when mortality rates were low and there were few procedures carried out by the consultant in private practice (on which the mortality rates were based).<sup>1071</sup>

- *Hospital operators*

11.504 While BMI did not believe that deficiencies in this area were sufficient to establish an AEC, BMI told us that it fully supported the information-based proposals set out in the provisional decision on remedies. BMI was unequivocally supportive of PHIN's role being extended to perform the CC's proposals in this area, including wider PHIN membership. Finally, BMI suggested that patients and other commissioners would benefit from further performance indicators being published, such as access to diagnostic procedures and indicators around convenience and choice.<sup>1072</sup>

11.505 HCA strongly supported the CC's proposed remedies on consultant and hospital performance information and the use of PHIN as the information organization tasked with collecting and publishing the information. In addition to the information set out in paragraph 11.485, HCA suggested that the CC should mandate the collection of:

- (a) information on hospital transfers, including between different private hospitals and between private hospitals and the NHS; and
- (b) information on patient mortality rates whilst in hospital, within 30 days of discharge, and on the basis of diagnosis, treatment and specialty.

11.506 HCA argued that the £5 million revenue threshold for inclusion in the remedy should be removed and that it should apply to all operators, including NHS PPU's and cosmetic surgery providers, licensed by the CQC to provide privately-funded hospital outpatient, day-case and inpatient treatments in the UK. HCA put forward the view that this would encourage competition by ensuring that the results of smaller operators could be compared against those of larger operators to build a comprehensive profile of the market.

11.507 HCA was supportive of collecting procedure-specific measures of improvement in health outcomes in principle but asked the CC to consult further with PHIN on increasing the number of procedures for which this measure would be available and identifying the most appropriate measures (see paragraphs 11.521 to 11.524).<sup>1073</sup> HCA suggested that overseas patients from EEA countries could be identified using their European Health Insurance Card (EHIC) numbers.

11.508 HCA agreed with the CC that the diagnostic coding system should be to an internationally recognised standard (eg ICD 10, and then 11 when it is introduced in 2015). HCA believed the standard adopted should be synchronised as far as possible with the standard adopted at any time by NHS England.

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<sup>1070</sup> [Aviva response to provisional decision on remedies](#), section 4.

<sup>1071</sup> [ibid](#), Section 5.

<sup>1072</sup> [BMI response to provisional decision on remedies](#), paragraphs 5.9–5.12.

<sup>1073</sup> [HCA response to provisional decision on remedies](#), section 11.

- 11.509 HCA supported making the raw data fully available to all relevant interested parties, inferring from this proposal that the CC would require full transparency of activity volumes from hospital operators from April 2017 at the latest.
- 11.510 HCA strongly supported the CC's proposals and timings regarding procedure coding and the movement from CCSD to OPCS coding by April 2019. HCA strongly supported the CC's proposal that the CMA reviews this remedy. However, HCA recommended the review happens five years after the publication of the CC's final report, which could be between April 2019 or at the latest April 2020, not five years after implementation of the remedy, which could be as late as April 2022.
- 11.511 HCA strongly supported the proposal that the CMA should nominate two of the non-executive board members of the information organization and submitted that the independent chair and the original board members should also be approved by the CMA. It also suggested that the chair should nominate new board members. HCA recommended that the following issues should be supported by the independent chair and at least one of the CMA-nominated board members:
- (a) the five year plan and initial budget;
  - (b) annual reports;
  - (c) annual budgets and subscription rates; and
  - (d) new board members.
- 11.512 HCA proposed that subscription fees should be set in direct proportion to the number/volume of publicly- and privately-funded patient episodes of inpatient treatments reported by member organizations to PHIN in the previous calendar year, with voting rights at general meetings of the information organization being in direct proportion to subscriptions paid.
- 11.513 HCA believed that the proposed single remedy, as modified in accordance with HCA's comments above, would be the least onerous necessary to secure adequate, consistent and transparent supply-side information on the quality and safety of private healthcare services.
- 11.514 Spire told us that it was fully supportive of efforts to increase the information available to patients regarding the quality of private healthcare in order to support patient decision-making. Spire emphasized that it fully supported PHIN's submissions on these areas but highlighted a few areas where it considered that clarification was required. These were:
- (a) The range of information to be published should be determined by the factors that *patients* perceived to be relevant to their decision-making, and should not be influenced by [X]. Spire suggested that the inclusion of non-executive members representing the interests of consumers and those nominated by the CMA should assist in achieving this objective, but it will be important to set out specifically the objectives of the organization in the terms of the remedy to ensure its effectiveness.
  - (b) Given the sensitivity of patient data, privacy considerations must trump an interest in providing access to a wide group of interested parties. To comply with applicable data protection rules, it is essential that adequate data security provisions be put in place.

(c) When stakeholders published excerpts from the data and analysis, they should be required to state clearly that a broad range of quality data was available through the information organization and link back to the information organization's website where the data was provided in an electronic medium. Such an approach would help to raise patient awareness of the availability of data to assist their decision making and help to ensure that patients can assess an objective and unbiased version of the data.

11.515 Spire also suggested that the information organization might license access to its database in order to both regulate access to the data and generate revenue to fund its operations.<sup>1074</sup>

11.516 Nuffield told us that while it did not believe that all of the metrics set out in paragraph 11.485 would necessarily help patients and/or GPs judge hospital and consultant quality, it considered that they did represent a useful first step toward addressing informational asymmetries in the market. However, Nuffield highlighted concerns that if certain anticompetitive behaviours were not addressed by other remedies, then even the dissemination of the right data would be likely to prove distortionary. For example, Nuffield noted that it had no issue with volume data being published, and that in a market where each operator competed on an equal footing for insured and self-pay patients, such data would be likely to provide useful information to prospective patients. However, in markets where a provider was excluded from one or more insurer networks, consultant drag would be likely to result in a disproportionate number of patients flowing to any included hospitals, in spite of the relative quality of each hospital's offering. In such instances, volume data could drive further concentration in local markets, amplifying the already problematic consultant drag effect.

11.517 Furthermore, Nuffield expressed reservations as to whether the dissemination of better-quality information would have a significant impact on the prices charged for insured patients:

While Nuffield agrees that the capacity of PMIs to judge value for money will increase with better quality information, we think it is important not to overstate the pricing benefits for insured patients. Ultimately, pricing at hospitals will be driven by the outside options available to both insurers and hospital operators during national negotiations.<sup>1075</sup>

11.518 Ramsay was generally supportive of the proposed remedy on consultant and hospital performance information subject to ensuring that the information published related directly to the quality of the services provided and that its publication did not have any anticompetitive effects. Ramsay highlighted that it did not consider information on the volume of procedures to be directly relevant to an assessment of quality and that such information might distort competition by embedding the position of high-volume providers as referring clinicians 'could erroneously equate high volume with quality'. Moreover, such information may allow hospital operators to monitor the procedure volumes of rival operators and use that information to adjust the way they competed.

11.519 Ramsay expressed concern that by making the raw data available to the insurers, the remedy may have the unintended consequence of giving Bupa an advantage over its smaller competitors, with the latter less able to make use of the data.<sup>1076</sup>

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<sup>1074</sup> [Spire response to provisional decision on remedies](#), paragraphs 5.1–5.6.

<sup>1075</sup> [Nuffield response to provisional decision on remedies](#), section 3.

<sup>1076</sup> [Ramsay response to provisional decision on remedies](#), section 5.

11.520 Circle told us that it was supportive of the proposals in the provisional decision on remedies for the provision of information on hospital and consultant quality information.<sup>1077</sup>

- *Others*

11.521 PHIN welcomed the CC's proposed information remedy. It stated that it was keen to fulfil the role of information organization and endorsed the recommended changes to governance, membership and funding as constructive and appropriate.

11.522 PHIN made a number of proposals regarding the specification of the information remedy, including:

- (a) removing the exemption from inclusion for providers of cosmetic surgery;
- (b) including mortalities and unplanned transfers for relevant procedures in the information collected and published;
- (c) that information on DVTs, or a related measure such as the rate of providing prophylaxis for DVTs, might be useful to patients—although new measures would need to be developed—but that data on cardiac arrests could be misleading;
- (d) Whether it was achievable to collect procedure-specific performance measures across ten procedures given that the NHS currently collected such data on three procedures only (with a generic EQ-5D measure for inguinal hernias). PHIN had started to explore the development of PROMs with a range of stakeholders, including private hospital operators and insurers, but thought that a fixed target of ten measures was not appropriate at this stage;
- (e) it should have discretion over the extent to which it shared data with commercial organizations, such as Dr Foster, Laing & Buisson and others; and
- (f) the sharing of data with third parties, such as the CQC or HSCIC, must be subject to appropriate agreement and suitable information governance arrangements, including the protection of commercial confidentiality where appropriate and necessary.

11.523 As regards the governance of the information organization, PHIN proposed that:

- (a) The CMA-nominated directors should be independent of, ie not representatives of, the CMA.
- (b) The PHIN board should be expanded from the current five<sup>1078</sup> to ten board members, with the additions comprising:
  - (i) two CMA-nominated non-executive directors;
  - (ii) an insurer-nominated non-executive director;
  - (iii) a non-executive director to represent consultants; and
  - (iv) a medical non-executive director to give a professional, non-representative perspective.

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<sup>1077</sup> Circle response to provisional decision on remedies, paragraph 3.2.

<sup>1078</sup> The current board members of PHIN are listed on the website: [www.phin.org.uk/About.aspx](http://www.phin.org.uk/About.aspx).

- (c) Any nominated non-executive director, including those nominated by the CMA, would need to be elected to the board by members at a General Meeting and hence to command the broad support of the full membership.
- (d) Director nominations should remain a matter for the board as a whole or for members, rather than for the Chair individually, in line with best practice in corporate governance which favoured collective decision-making.
- (e) The CMA-nominated members should have authority and influence no greater nor less than that of their fellow non-executive directors and should be subject to the same fiduciary duties, save that the CMA-nominated directors should:
  - (i) make a statement in the information organization's annual report on their satisfaction (or otherwise) with the overall independence, effectiveness and good governance of the organization in the preceding year, and set out what measures the board had agreed to adopt in the following year to rectify any deficit;
  - (ii) in extremis, if they believed that the board was unable effectively to direct the company to achieve its objectives, have the authority to call for a review of the remedy by the CMA within a five-year period; and
  - (iii) have authority to approve minor variations to the CC's information remedies where they recognized that the intention of those remedies could be fulfilled satisfactorily but where a strict interpretation could be detrimental or unnecessarily cumbersome or expensive.

11.524 PHIN welcomed the proposal to expand its membership base to include the PMIs but suggested that consultants should be represented at board level rather than becoming individual members, since this could make the organization unwieldy.<sup>1079</sup>

11.525 FIPO welcomed the CC's proposal that the industry should move towards standardized coding under the OPCS rather than the CCSD system, although it suggested that the transfer could be achieved in a shorter time frame than the five years envisaged in the provisional decision on remedies. FIPO argued that the provision of quality information would not be effective if patients were not able to choose consultants freely rather than being constrained in their choice by insurers under 'open referral' policies. FIPO expressed a concern that rather than a 'race to the top' resulting from the publication of fees without quality information, at the current time it considered that there was a 'race to the bottom' being generated by the insurers and their approach of derecognizing consultants whose charges were in the top 10 per cent of all consultants.

11.526 FIPO argued that 'it would not make sense to have different quality indices applied due to the use of different statistical tools and assumptions about raw data by different organisations'. FIPO were of the view that if PHIN were to be the organisation to publish metrics and quality indexes, then other organisations should not be given access to the raw data underlying such metrics, as 'if the PMIs (and others) are to be allowed to apply different quality parameters than PHIN, this calls into question the very existence of PHIN'.

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<sup>1079</sup> PHIN response to provisional decision on remedies.

11.527 The AAGBI was supportive of the proposed remedies to improve the availability of performance information on consultants and hospitals but considered that there were still some important issues to address, including:

- (a) The AAGBI thought that information on the level of PMI benefits should be included alongside the other information in order to allow patients to compare costs and their cover easily and therefore shop around for the best deal, both when seeking treatment and when choosing an insurer.
- (b) PMIs should not have executive authority or membership of the information organization, while consultants should be represented at the executive level and in the membership base in equal proportion in terms of voting power.
- (c) The AAGBI expressed concerns that the insurers might misuse the raw data collected by the information organization for commercial gain, particularly given that consultants could easily be identified by their GMC number. They suggested that the information organization should replace this with pseudo-anonymous consultant identifiers before releasing the data.

11.528 The BMA was supportive of the information remedies proposed by the CC, but raised some concerns around the possibility that patients could be identified from their NHS numbers, the speed with which the CC had proposed that insurers should move from CCSD to OPCS coding and the extent to which PMIs would be able to continue to direct patients even after the publication of consultant (and hospital) performance information.

11.529 The BMA supported the role of PHIN as the information organization on the conditions that it was truly independent from hospital providers and PMIs, and that consultant representatives should be able to influence meaningfully the interpretation and presentation of consultant data. The BMA suggested that as the recognized trade union and professional association for doctors, it should have an active role in the organization to ensure that doctors' interests are effectively represented.

11.530 CCSD put it to the CC that by mandating the use of OPCS rather than CCSD codes, the CC would create significant complexity and transition costs for the sector without improving the transparency of information. In particular, CCSD argued that:<sup>1080</sup>

- (a) OPCS was not designed to be used for payments or billing and hence contained codes that were unnecessary from a commercial point of view as well as vague codes, such as 'unspecified'.
- (b) OPCS was only updated only once a year, which was too infrequent to accommodate fair payment for emerging treatments.
- (c) OPCS was based on NHS activity and therefore might not cover all activity covered by private medical insurance.

11.531 In contrast, CCSD argued that its coding system was designed for PMI commercial use, updated monthly based on the introduction of new treatments into PMI, and enabled separate payments to hospitals and healthcare professionals.

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<sup>1080</sup> [CCSD response to Remedies Notice](#).

## *Our assessment of the hospital and consultant performance information remedy*

11.532 We reviewed the information remedy proposed in the provisional decision on remedies (and summarized in paragraphs 11.485 to 11.490) in light of the submissions from the insurers, private hospital operators and other parties. In this section, we set out the factors that we have taken into account in designing the remedy, before considering its effectiveness and proportionality.

### *Design considerations*

11.533 In order for patients to make meaningful choices between consultants and hospitals based on quality, we reasoned that they and their representatives<sup>1081</sup> would need to have access to information that was relevant, accurate, comparable, and easy to understand. This means, among other things, that:

- (a) Performance measures published should be those most relevant for patients in making their choice. These are likely to vary according to the type of procedure and the preferences of the patient.
- (b) The same information should be collected on all hospitals or consultants with private practice in a given specialty, with raw data risk-adjusted where appropriate to ensure like-for-like comparisons.
- (c) There should be a sufficient but not excessive range of performance measures published to allow patients to make comparisons on several bases, whilst avoiding 'information overload'.
- (d) Data should be presented in a format that allows patients to *compare* the performance of two (or more) consultants or hospitals easily, with graphics used to enhance understanding of the data and comparability.
- (e) Interested parties should be able to scrutinize, evaluate and critique the data and its analysis to ensure that it is robust and seen to be robust by all industry participants, hospitals, consultants, insurers and patients. Such confidence in the data is essential to its usefulness for all parties.

11.534 We note that the challenge of providing relevant, accurate and comparable data on both hospital and consultant performance is significant, with the NHS in England only recently starting to publish limited data in this respect. In considering the parties' submissions on the provision of hospital and consultant quality information, and reaching our conclusions, we have sought to recognize the scale of this challenge and achieve the correct balance between the information needs of patients and the feasibility (and costs) of substantially increasing the availability of performance information where, in many cases, new methodologies may need to be devised to collect and analyse the data.

- *Scope of the performance information remedy*

11.535 We considered PHIN and HCA's argument that it would be desirable for cosmetic surgery providers to contribute performance information for analysis and publication via the IO. We reasoned that the AEC that we found in relation to the lack of performance information on consultants and hospitals was a market-wide issue. While

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<sup>1081</sup> In this context, patients' representatives include their GPs, consultants and, where relevant, PMIs.



sectors such as cosmetic surgery may provide more information on certain aspects of outcomes,<sup>1082</sup> we did not find that patients had access to the type of statistically robust, comparative information that our proposed remedy would provide. We also noted the findings of the Keogh report on cosmetic surgery which recommended the development of evidence-based standardised patient information.<sup>1083</sup> We concluded, therefore, that cosmetic surgery providers should not be excluded from our remedy.

11.536 We considered HCA's arguments for including all private hospital operators within the information remedy on the basis that this would be more effective in encouraging competition by ensuring that the results of smaller operators could be compared with those of larger operators. We noted that the £5 million turnover threshold had originally been set in order to avoid requiring a large number of clinics providing only outpatient consultations and treatments from being required to submit data to the IO. However, we agreed that in order to be effective in addressing the AEC, the remedy would need to ensure that patients had access to performance information on substantially all hospitals and consultants providing acute medical treatments or surgery in order to make informed comparisons. We reasoned that this information was just as important to the patients of small PPUs and clinics specializing in cataract surgery, for example, as it was for patients of large, full-service private hospitals.

11.537 We considered whether to include outpatient-only facilities in the remedy but concluded that the practical issues (and costs) for the IO associated with managing submissions from a very large number of small facilities was likely to undermine the efficacy of the remedy and was disproportionate. Furthermore, given the relatively minor nature of the treatments carried out at such facilities,<sup>1084</sup> we concluded that widening the scope of the remedy was not only practically difficult but also unnecessary in order for the remedy to be effective in addressing the AEC found. Therefore we concluded that all private hospitals and clinics, including NHS PPUs, that are both registered with the CQC and admit patients for treatment on either an inpatient or day-case basis, be required to submit the relevant information to the IO.

- *Information requirements*

11.538 We thought that the proposal by HCA and PHIN to include data on mortality rates and unplanned transfers in the information collected and published would aid patients and their agents (GPs and PMIs) in identifying the appropriate consultant and/or hospital for their treatment. It would, therefore, ensure the effectiveness of the remedy and we concluded that it should be included in the relevant information that the private hospital operators would be required to provide.

11.539 We noted PHIN's concerns regarding the potential for information on cardiac arrests to be misleading and the need to develop new processes and measures to collect useful information on DVT occurrence or prophylaxis. In light of this, we thought that including such information might undermine the effectiveness of the remedy. We concluded, therefore, that while we would encourage a suitable IO to research these areas and come to agreement with its members (including the private hospital operators) regarding which information it would be useful to collect, we did not consider it appropriate to require that the hospital operators provide this information.

11.540 We considered Bupa's argument that we should mandate consultants to contribute information to relevant clinical registries as appropriate. Our proposed remedy speci-

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<sup>1082</sup> For example, we noted that many clinics provided 'before' and 'after' photos as well as patient testimonies.

<sup>1083</sup> [Review of the Regulation of Cosmetic Interventions](#), Keogh et al, April 2013.

<sup>1084</sup> We considered that the value of the type of performance information that this remedy seeks to ensure is made available to patients was lower for relatively minor treatments, such as mole removal.



fied that the private hospital operators should collect and submit this information for processing and publication as appropriate and where available. Therefore, we considered that this issue had already been addressed.

11.541 We next considered BMI's argument that patients would benefit from greater information on access to diagnostic procedures and indicators of convenience and choice. We observed that PHIN's website already provides information on the distance of a facility from patients' addresses, which gives patients an indication of the convenience of a particular operator. Furthermore, the hospital operators' websites tend to provide information on their location as well as on the diagnostic facilities that they offer.<sup>1085</sup> We did not think, in general, that patients would require the same type of performance information on such tests as they would on procedures and, therefore, we concluded that there was not a clear need to require the private hospital operators to collect and publish this information. However, we reasoned that if they considered that there was a reason to do so, they could publish additional information to that set out in this remedy, either via the IO or any other channel they wished.

11.542 We reviewed the suggestions made by Bupa and HCA regarding how international patients should be identified. We thought that both suggestions were sensible but reasoned that the IO would be best placed to determine the optimal system for identifying international patients. We noted that this may be determined, in effect, by how such patients were identified within the NHS given the need for comparability. For the remedy to be effective, we thought it was only necessary for us to require the hospital operators to identify international patients according to whichever system the IO reasonably determined was practical.

11.543 We reconsidered the number of procedure-specific measures of improvement in health outcomes in light of both Bupa's and PHIN's submissions on these. We agreed with Bupa that the remedy would need to ensure that these measures were made available to patients on as wide a range of procedures as possible. However, we thought that it was also necessary to ensure that the information provided was robust, useful to patients in assessing performance and useful to clinicians in identifying how to improve patient care, comparable to any similar measures collected for NHS patients, and proportionate in terms of ensuring value for money. On this basis, we reasoned that the dual aims of effectiveness and proportionality would be best served if the IO worked with its members and other stakeholders to identify procedures for which the collection and analysis of PROMs data would be both useful and cost-effective and to develop appropriate methodologies for collecting and analysing data in these areas. We would require that the private hospital operators collect and submit for publication the information needed to support the production of PROMs data for those procedures agreed by the IO to be robust and cost-effective.

11.544 In reviewing the effectiveness of our remedy and the continuing suitability of the IO, we will take into account the extent to which the PROMs-type information provided to private patients matches or exceeds that collected within the NHS. We note that it may be preferable in terms of enhancing the availability of performance information to patients for such measures to be collected on different procedures for private sector patients than for NHS patients, given the differences between the sectors.<sup>1086</sup>

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<sup>1085</sup> For example: [www.thewellingtonhospital.com/About-Us-Diagnostics.aspx](http://www.thewellingtonhospital.com/About-Us-Diagnostics.aspx); [www.spirehealthcare.com/bushey/diagnostic-services/](http://www.spirehealthcare.com/bushey/diagnostic-services/).

<sup>1086</sup> For example, if the IO determined that a specific measure of improvement in eyesight following cataract surgery was of greater benefit to private patients than a measure of health improvement following treatment of varicose veins, we consider that it would be more effective for the IO to collect the former rather than the latter.

11.545 We agreed with Bupa that in order to maximize the effectiveness of the remedy, information should be published as early as possible. We also reasoned that the information published would need to be kept up to date to ensure its ongoing relevance to patients and, thereby, the longer-term effectiveness of the remedy. To date, PHIN has published performance information on behalf of the PHPs as it has become available and we considered that it would be appropriate and necessary to include a similar provision as part of our remedy, although without altering the deadlines set out in paragraph 11.486. As regards the timeliness of the data, we concluded that the information published should be updated at least quarterly to ensure its relevance for patients.

- *Coding*

11.546 We reviewed the insurers' arguments against requiring the industry to move towards OPCS coding and away from CCSD coding. Our primary concern in specifying that OPCS codes should be collected was to ensure that the information provided to the IO for processing and publication contained a type of procedure coding that facilitated the production of performance measures.<sup>1087</sup> PHIN told us that OPCS coding was preferable to CCSD as it ensured the direct comparability of private and NHS data and facilitated the checking of data sets by the providers of the information, whether hospitals or consultants.<sup>1088</sup> In the provisional decision on remedies, we proposed that the insurers should move towards the NHS system in order to avoid the hospital operators being required to provide two sets of codes (CCSD and OPCS) in perpetuity. However, we shared the insurers' concerns that switching coding systems would be costly and disruptive, in terms of changing IT systems, renegotiating contracts, and (potentially) creating inflation in claims costs. Furthermore, we recognized that there were issues in terms of using OPCS coding for billing purposes as it contained a significantly larger number of codes but also did not cover areas such as high-cost drugs and outpatient consultations.

11.547 We concluded, therefore, that it was not necessary for the effectiveness of our remedy for the industry to change its billing system but only for the hospitals to provide procedure coding on the same basis as the NHS, ie OPCS coding, and have, as a result, removed the requirement on the insurers to transition to the OPCS system.

11.548 We reviewed Bupa's argument that, in addition to applying diagnostic coding for each patient (or patient episode), the private hospital operators should be required to collect co-morbidity data. At the time of drafting the provisional decision on remedies, we had understood that co-morbidity information would be included within a robust system of diagnostic coding, such as ICD-10. We agree that such information is essential to allow the production of meaningful information for patients as, without this data, it is not possible to distinguish between consultants and hospitals with poorer outcomes and those with sicker patients. Therefore, we considered that, to the extent that such co-morbidity data was not included within the diagnostic coding provided by the private hospital operators, it should be separately provided.

- *Data protection*

11.549 A number of parties raised concerns about the protection of both patient and commercial data. In particular, there were concerns that individual patients should not be

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<sup>1087</sup> Diagnostic coding indicates what was wrong with a patient and what their other risk factors were, such as diabetes or obesity. Procedure coding indicates exactly what treatment a patient received.

<sup>1088</sup> [Summary of hearing with PHIN](#), paragraph 19.

identifiable from the raw data sets, and that competitors or insurers should not be able to use the information to gain a competitive or negotiating advantage.

- 11.550 We noted that a suitable IO would have a legal responsibility to protect sensitive patient-level data, ensuring that it was suitably anonymized before being released to any third parties. We considered that the board of the IO would need to ensure that it had the information governance systems in place to ensure compliance with all relevant legislation but we did not consider that it was necessary for our remedy to specify how to achieve this given the existence of a clear legal framework.
- 11.551 We recognized that there were a number of legitimate concerns regarding the commercial confidentiality of the information, such as detailed volume data. We noted that, in certain circumstances, the sharing of such information also had the potential to be anticompetitive. We reasoned that the criteria for a suitable IO would include the requirement that the organization was capable of processing and publishing the relevant information in a timely manner. On this basis, we did not consider that there was a clear need for other organizations in the sector to have access to the underlying raw data in order for our remedy to be effective. Indeed, as PruHealth highlighted, risk-adjusting healthcare data is a complex task and we thought that there might be a risk in third parties conducting their own analysis, without the quality checks and balances of a suitable IO, and publishing results which may be misleading to patients.
- 11.552 We did not consider it appropriate or necessary to prohibit the disclosure and provision of this information to other organizations. We reasoned that if the IO, in agreement with its members, chose to share its information database among members of the IO or with third parties,<sup>1089</sup> it should be able to do so. However, for our remedy to be effective, we did consider that it was important that patients and stakeholders could have confidence in the quality of the data published and that this would necessitate that the IO make available to stakeholders—and consult on—the methodology applied in analyzing and aggregating the data prior to publication. In addition, we thought that a suitable IO would need to submit its data collection and analysis processes for an independent, periodic audit to ensure that stakeholders were able to gain comfort regarding the accuracy/impartiality of the published information.

- *Information organization*

- 11.553 We received a large number of submissions regarding the composition, governance, funding and operations of a suitable IO, as well as views as to whether or not PHIN would be a suitable IO for the purposes of facilitating this remedy. In this section, we set out our consideration of the proposals made by the parties regarding the criteria for a suitable IO. We also address whether PHIN could be considered to be a suitable IO.
- 11.554 In general, the parties were supportive of the criteria set out in the provisional decision on remedies for the suitable IO, namely that it should be independent but able to work with all stakeholders in the industry, that it should be transparent, and that it should be funded and resourced to enable it to deliver high-quality performance measures in a timely manner. We reasoned that these criteria were essential to ensure the robustness of the information published, and thereby the effectiveness of the remedy.
- 11.555 As regards the independence and expertise of the organization, the parties which responded to the provisional decision on remedies supported the proposal that the

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<sup>1089</sup> In particular, we thought that it might be beneficial to the sector to share this data with regulators such as the CQC.

CMA should nominate board members to ensure the smooth running of the IO.<sup>1090</sup> We thought that the inclusion of such members on the board of an IO were important for ensuring that disagreements among members of the IO did not prevent it from achieving the legitimate aim of the remedy, ie the provision of performance information to patients. We agreed with Bupa's argument that the independence of the IO would be enhanced by ensuring that representation on the IO's board was balanced between the PHPs, insurers and patient groups and that consultants should be represented by one or more board members from the Royal Colleges or professional bodies. Similarly, we thought that an independent IO would need to offer membership to all private hospital operators and insurers, as well as to a limited number of consultant bodies to ensure a balanced representation of views.

11.556 In terms of the criteria that the IO would need to meet in terms of competence, we reasoned that it would need two or more board members, whether executive or non-executive, with significant experience and expertise in the collection and processing of private healthcare performance information. In addition, we thought that an important criterion for a suitable IO would be a demonstrated ability to work with academics, professional bodies and other healthcare organizations to develop, refine and publish relevant hospital and consultant performance measures.

11.557 Next, we considered the criteria that an organization would have to meet in terms of transparency in order to be considered a suitable IO. In paragraphs 11.551 and 11.552, we highlighted that a suitable IO should be prepared to make public and consult (with relevant stakeholders) on the methodologies it would apply in processing and risk-adjusting data in order to produce performance measures that are meaningful for patients. We also emphasized that, in order for patients and other stakeholders to have confidence in the data, it would be necessary for the IO to arrange for its data sets and processing to be audited by an independent party who would report its findings publicly.

11.558 The parties that responded to the provisional decision on remedies did not generally make many suggestions regarding the level of transparency of the organization. As set out in the provisional decision on remedies, we considered that in order to meet the general criterion of 'transparency', an IO should draw up a five-year plan setting out how it proposes to collect the information specified by this remedy, a timeline for the publication of the various performance measures and a detailed budget for the organization, taking into account the information requirements and structure of the organization set out in this remedy. This plan should be agreed by the members of the IO and approved by the CMA. We reasoned that it should also be published on the IO's website to ensure that all stakeholders, including patients, were aware of what information would be made available and when.

11.559 In addition, we considered that the IO would need to produce an annual report, setting out its progress against its five-year plan, explaining any changes to the timetable or the nature of the information collected, and providing a reasonable level of financial information for members to understand how their funds have been used. We thought that the IO should also publish its board minutes to ensure transparency.

11.560 Finally, we considered how the IO should be funded. We thought that for this remedy to be effective, the private hospital operators would need to provide information to the

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<sup>1090</sup> Bupa suggested that these members should, among other things, provide guidance on competition law compliance, while PHIN argued that the CMA-nominated members should be completely independent of the CMA to avoid any issue of the CMA being considered to be a shadow director of the information organization. We reasoned that the role of the CMA-nominated directors was to ensure the smooth and effective running of the organization rather than to represent the CMA itself and therefore it was appropriate for these directors to be independent of the CMA and focused on ensuring the effectiveness and good governance of the organization rather than on providing legal guidance to members.

IO that met the criteria set out in paragraph 11.570 and enabled the IO to process and publish the information in a manner that would allow patients without any particular expertise to make meaningful comparisons across hospital operators and across consultants. In order to ensure that the information was published in the manner required and to ensure both the comparability and the reliability of it, we considered it necessary to require the private hospital operators to cover the reasonable costs of the IO in processing the information into a format that is comparable and comprehensible to patients. We considered that an approved IO should be free to determine how it is funded, for example through subscriptions from across its membership base. However, to ensure the efficacy of our remedy, we considered it necessary to ensure that the approved IO is sufficiently funded. Therefore, we considered that, where necessary, the private hospital operators should provide funding that the approved IO requires to process and publish the relevant information, as set out in this remedy. We reasoned that it would be fair for funding to be made in proportion to the number of patients treated by each private hospital operator in the preceding calendar year.

11.561 We agreed with Spire that, in the future, the IO may seek to cover some of its costs by licensing access to its database (subject to appropriate data protection measures). However, we thought it would be appropriate to allow the IO's funders to determine how and when it would be appropriate to do this.

11.562 We next considered whether PHIN met these criteria for a suitable IO. We first examined AXA PPP's argument that PHIN was not an organization that insurers could trust to work with given its historic links with the private hospital operators, FIPO and the Private Patients' Forum. We recognized that PHIN was founded by the private hospital operators rather than by the insurers and therefore has had stronger links with the hospitals up to now. However, we observed that PHIN's board members had been drawn from a range of backgrounds within the sector, including insurers, independent hospital representative groups, private patient groups and an academic organization, which we thought would be likely to provide a good foundation for a robust, independent organization. We thought that the concerns of AXA PPP (and some others) in relation to the independence of PHIN as a suitable IO could be addressed by:

- (a) the opening of PHIN's membership base to include the insurers; and
- (b) the appointment of additional non-executive directors to PHIN's board, nominated by or representing the insurers and consultants, as well as independent, CMA-nominated directors.

11.563 We noted that PHIN had indicated a willingness to make these changes, proposing to open its membership to the insurers and appoint five additional non-executive directors nominated by the CMA (two directors), insurers (one director) and consultant/professional bodies (two directors).

11.564 As regards competence, we thought that PHIN's existing board members appeared to have significant expertise in healthcare and the management of information in healthcare. For example, Andrew Vallance-Owen (Chairman) was Chief Medical Officer of Bupa for 17 years and chairs the Department of Health's PROMs stakeholder group,<sup>1091</sup> while John Appleby is Chief Economist at the King's Fund, a UK-based healthcare think tank.<sup>1092</sup>

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<sup>1091</sup> [www.phin.org.uk/About.aspx](http://www.phin.org.uk/About.aspx).

<sup>1092</sup> [www.kingsfund.org.uk/about-us](http://www.kingsfund.org.uk/about-us)

11.565 We considered AXA PPP's suggestion that Dr Foster would be an alternative suitable IO. We thought that this was possible but we observed that Dr Foster had not put itself forward as a suitable IO, which PHIN had done. We observed that, in light of PHIN's willingness to adapt to meet our criteria, it would be a suitable IO for the purpose of implementing this remedy-

11.566 However, we considered that a number of detailed governance issues would need to be resolved by PHIN before it could be approved. These are:<sup>1093</sup>

- (a) the process by which new non-executive directors would be nominated and then approved by PHIN's board;
- (b) the rules governing decision-making by the board of PHIN and within the organization more generally, including, for example, which matters need to be put to a member vote and which can be determined by the board;
- (c) the organizations (insurers and consultant bodies) to which PHIN would propose to extend membership and voting rights, together with details of the basis on which voting rights would be allocated to members;
- (d) the matters that should be reserved to the CMA-nominated directors to ensure the smooth running of the organization and thereby the effectiveness of the remedy;
- (e) what powers PHIN should have to vary the information collected and published and how this should be agreed with members; and
- (f) any dispute resolution procedures that it considers may be necessary in light of its expanded membership base.

11.567 Stakeholders would be consulted on this proposal during the remedy implementation phase with the CMA taking into account their views, including the views of any other suitable candidate organizations before approving the IO to facilitate this remedy.

- *Other matters*

11.568 Several submissions specified how certain data should be collected and/or analysed in order to ensure its integrity.<sup>1094</sup> We consider that ensuring the robustness and integrity of information is one of the primary responsibilities of the IO and that it should be given the flexibility to determine how best to achieve this end for each type of data.

*Summary of revised remedy*

11.569 In this section, we set out a brief summary of the revised performance information remedy that we consider will provide a comprehensive solution to the AEC that we have found.

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<sup>1093</sup> We note that these issues and others may be covered in the proposed Articles of Association and other governing documents of the information organization.

<sup>1094</sup> For example, see Bupa's comments in paragraph 11.493 regarding standardized templates for collecting patient feedback.

11.570 We will require that all operators of private healthcare facilities<sup>1095</sup> in the UK that admit patients for treatment provide patient episode data for all patients treated at their facilities to an IO approved by the CMA for processing and publication. This information should be sufficiently detailed and comprehensive to ensure that the following types of performance measures at both the hospital and consultant level can be published:

- (a) volumes of procedures undertaken;
- (b) average lengths of stay;
- (c) infection rates, surgical and hospital-acquired;
- (d) readmission rates;
- (e) revision rates (where appropriate);
- (f) mortality rates;
- (g) information on hospital transfers, including between private hospitals and the NHS;
- (h) relevant information from clinical registries and audits as appropriate and where available;
- (i) a measure of patient feedback and/or satisfaction on the service provided;
- (j) (as determined to be appropriate by the IO and its members) procedure-specific measures of improvement in health outcome; and
- (k) (if determined to be appropriate by the IO and its members) information on the frequency of adverse events, such as post-operative DVT and cardiac arrest.

11.571 In order to facilitate the analysis and publication of meaningful performance statistics, we would expect the data provided by the private hospital operators to:

- (a) include the GMC number of the consultant responsible for each patient episode occurring in the operators' facilities;
- (b) include the NHS number of UK patients or alternative information from which patients' NHS numbers can be derived and a suitable equivalent identifier for non-UK patients;
- (c) contain diagnostic and procedure coding<sup>1096</sup> for each episode in order to allow for risk-adjustment where appropriate—diagnostic coding should include full details of patient co-morbidities;
- (d) be fully comparable with that collected by the NHS to allow the information organization to report performance measures for the whole of consultants' prac-

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<sup>1095</sup> This should include all hospitals and clinics providing secondary medical or surgical treatments to patients within the UK, including NHS PPUs and specialist clinics. It is not intended to include facilities providing consultations and treatments on an outpatient-only basis.

<sup>1096</sup> An appropriate diagnostic coding system should be an internationally recognized standard such as ICD 10 coding. We noted Bupa's argument that we should mandate the use of ICD 10 coding, but we thought that it was important to allow flexibility to the organization to ensure that it would maintain comparability with the NHS. We would expect the information organization to agree the appropriate system to use with its members.

tices, both NHS and private, since this is the relevant basis on which to judge performance;

- (e) be published in stages over the three years following the publication of our final report, with all data made available to the public from April 2017 onwards;
- (f) following publication, be kept up to date with the performance measures published being updated at least quarterly on an ongoing basis; and
- (g) be audited periodically by an independent party to maintain confidence in the data collection and analysis.

11.572 The processing and publication of the quality information will be facilitated by an IO approved by the CMA in accordance with the criteria set out above in paragraphs 11.553 to 11.567. We consider that publication should be made via a website operated and maintained by the IO in a format that permits patients to search and compare results easily.

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

11.574 We propose that the CMA should review this remedy in April 2019 to consider whether the information requirements have been met, whether the remedy is effective in enhancing the availability of performance information for patients and whether any adjustments or refinements are needed to the information published.

### *Conclusions on effectiveness*

11.575 We found that the lack of publicly-available information on consultant and hospital performance was a feature which distorted competition between consultants and between private healthcare facilities by preventing patients from exercising effective choice in selecting their private healthcare providers giving rise to an AEC. This remedy aims to address this AEC directly by ensuring the publication of a range of performance measures for both hospitals and consultants that are relevant in helping patients to make decisions and easy for non-experts to understand.

11.576 In order for the remedy to be effective, we thought that patients would need to be prepared to use the information provided, that the information should be robust and that it should serve to stimulate competition between hospitals and between consultants over areas of performance that matter to patients.

11.577 We first considered whether patients would use the data provided. Our survey indicated that 36 per cent of patients did discuss the clinical expertise of consultants with their GP,<sup>1097</sup> with 29 per cent reporting that 'quality of care' was one of the most important reasons for choosing a particular hospital.<sup>1098</sup> We believe that this demonstrates that at least a large minority of patients are interested in acquiring

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<sup>1097</sup> 39 per cent reported that they had discussed the reputation of the consultant with the GP, which is likely to be closely linked to clinical expertise.

<sup>1098</sup> Other factors cited by patients as being important in choosing which hospital included: the clinical expertise of staff (22 per cent) and the facility's clinical outcomes (17 per cent).



information on consultants' expertise and the quality of care provided by hospitals and that they are making use of some of the few sources of information currently available. We would expect these patients to use independent quality information if it were available to them. In addition, by requiring the insurers to inform patients of a new source of quality information, we would expect a larger proportion of patients to look for and use this data when making choices in the future. We reasoned that the remedy would be effective in stimulating competition between providers as it was likely that a significant minority of patients would use it to make decisions as providers would have an incentive to compete for the custom of these patients.

11.578 Even in the case where this information was not directly used by patients and the latter continued to rely on the advice of their GPs, we would expect GPs to make use of this additional information when advising patients. Our survey indicated that 81 (56) per cent of GPs felt that clinical expertise was the most important reason for recommending a particular consultant (hospital), and 26 (34) per cent of GPs reported that they would like additional information on consultant expertise (hospital clinical outcomes).

11.579 Bupa told us that patients were not the only or even the main users of information and that quality improvements could also be driven by scrutiny by organizations such as the CQC and the GMC, as well as by GPs and PMIs who would advise patients as to which consultants or hospitals to visit.<sup>1099</sup> We agree with this view and expect that patients' agents, including insurers and GPs, will use the data to advise patients which provider to use. The publication, comparison and analysis of information on healthcare outcomes allows for the identification of more and less efficient treatment pathways, stimulating competition on the whole value proposition offered to patients, ie information that health outcomes are better using one treatment pathway rather than another should stimulate a change in practice among consultants. PruHealth told us that the combination of diagnostic and treatment coding for each patient, together with outcome data, would allow it to identify which hospitals were providing better value, or more efficient care in terms of achieving the same healthcare outcomes at lower cost. PruHealth suggested that this type of information would allow it to challenge hospitals and/or consultants on an informed basis with regard to the effectiveness and efficiency of their treatment choices. We consider that this type of information should, therefore, allow PMIs to stimulate competition between healthcare providers on the value they offer, with benefits in terms of improvements in quality and reductions in price for patients.<sup>1100</sup>

11.580 However, we also note the concerns expressed by FIPO and numerous clinicians that the interests of the insurers are not necessarily aligned with those of patients. Therefore, we believe that it is appropriate for an independent organization with appropriate expertise in healthcare data management and approved by the CMA to collect, analyse and publish this data and that this should be the primary data source to which patients should be referred. We note that our remedy provides both for all stakeholders in the industry to contribute ideas and expertise to the design of the performance measures and for the auditing of the data and its processing. We consider that this should ensure the robustness of the information provided to patients.

11.581 We considered AXA PPP's arguments that the type of data that this remedy would provide was not suitable for ranking consultants and hospitals, and that it would be unreliable due to the poor quality of clinical (ICD) coding. We agreed that mortality rates were not likely to be a useful means of ranking consultants and hospitals and

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<sup>1099</sup> BUPA response to Remedies Notice, paragraph 6.9.

<sup>1100</sup> Summary of hearing with PruHealth, paragraphs 1–4 & 29–31.

we took this into account in specifying that a broader range of performance data should be collected and made available, including PROMs-type information, infection rates, readmissions and patient feedback (among others). We would expect the IO, with input from medical professionals and academics, to analyze and present this data in a meaningful way to patients, avoiding rankings where the differences in performance were not statistically significant.<sup>1101</sup>

11.582 We observe that while the original aim of the cardiothoracic data collection exercise (to which AXA PPP referred) was to identify outliers rather than to rank consultants and hospitals, as set out in paragraph 11.586, the realized impact on mortality rates (ie performance) was much more significant than would have been achieved only through the elimination of those outliers. It appears that the publication of the data stimulated a specialty-wide improvement in outcomes.

11.583 As regards the use of clinical coding, PHIN told us that some industry participants currently used high-level ICD-9 coding, which is significantly less detailed than the ICD-10 coding system, particularly when combined with co-morbidity data.<sup>1102</sup> We thought that the IO would need to provide guidance to private hospitals on coding and put in place mechanisms to review the data submitted to verify its robustness. We recognize that there are likely to be a number of issues with collecting information for the first time. However, we concluded that the interests of patients were likely to be better served by having some, albeit imperfect, quality information, which could be reviewed, tested and acted upon by medical professionals than to avoid the collection and publication of such data because it was not always reliable.

11.584 Finally, we note the argument that transparency over outcomes at both the consultant and the hospital level can improve quality due to consultants and hospital operators becoming aware of better and worse practice and seeking to improve their position relative to their peers, ie performance improves because consultants and hospitals obtain a benchmark for their performance rather than because patients change their behaviour. Although our remedy is focused on providing patients with the information they need to make meaningful choices, we consider that this type of quality competition can yield significant benefits for patients and is reasonably likely to be a channel through which this remedy serves to improve the quality of privately-provided healthcare.

### *Proportionality*

11.585 We set out in paragraphs 11.575 to 11.584 the reasons we consider that this information remedy will be effective in achieving its aim. In this section, we consider the likely costs and benefits of the remedy before coming to a view as to whether it represents a reasonable and proportionate means of achieving its aim.

11.586 The provision of quality or performance information on hospitals and consultants is designed to increase competition among these providers for patients on this basis and thereby drive up the quality of healthcare services provided. Given the nature of 'quality' which can be demonstrated across a large number of factors, from mortality rates to customer service, it is not possible to provide any robust quantification of the likely effect. However, an example of the scope for improvement is given by The Society for Cardiothoracic Surgery in Great Britain & Ireland, which noted that, following the publication of mortality statistics:

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<sup>1101</sup> We were concerned that the NHS England data sets were insufficient due to their narrow focus on mortality rates and the potential for misinterpretation by laymen.

<sup>1102</sup> [PHIN response to provisional findings](#).

The degree of improvement is marked: between 2001 and 2008 the mortality rates decreased from 2.3 per cent to 1.5 per cent for isolated CABG,<sup>1103</sup> 2.6 per cent to 1.7 per cent for all CABG, 5.2 per cent to 3.5 per cent for isolated valves and 8.3 per cent to 6.1 per cent for combined valve & graft operations. All of these improvements are statistically significant.<sup>1104</sup>

This improvement in performance has generally been attributed to the publication of the data and the stimulus this provided to consultants to improve their practice.<sup>1105</sup> Even if improvements in outcomes in other specialties following the publication of performance data were less dramatic than in the case of cardiothoracic surgery, we consider it likely that the potential patient benefits from this remedy are very significant.

11.587 Although we consider that the main benefit of publishing performance information is likely to be greater competition for patients on the quality of treatment provided, we thought that the publication of such information could also serve to increase price competition between consultants and between hospitals by increasing the size of local markets and, thereby, the number of 'local' competitors. In our investigation, we have observed that patients are, in general, reluctant to travel significant distances for medical treatment, creating relatively narrow local markets.<sup>1106</sup> In many of these areas, we have found that private hospitals face weak competitive constraints. However, we considered it likely that, if patients had greater information on the quality of private healthcare, they may be more prepared to travel for a better-quality provider, expanding the size of local markets to include a larger number of private hospitals (and consultants). We thought that there was significant uncertainty around the likely magnitude of this effect and the time frame over which it would occur. However, we observed that if it were to increase the level of competitive constraints sufficiently to reduce total private-patient-only hospital revenues by 1 per cent, this would result in an annual benefit to patients of around £35.4 million per year, based on the market size as of 2011.<sup>1107</sup> We concluded that it was reasonable to assume an effect of this order of magnitude in light of the survey evidence indicating that 29 per cent of patients reporting that 'quality of care' was one of the most important reasons for choosing a particular hospital, which suggests that a significant proportion of patients would be prepared to travel further for a higher-performing hospital.

11.588 We considered the likely incremental costs of implementing this remedy. For example, at the current time, PHIN receives approximately £1.1 million of funding from the private hospital operators. PHIN told us that funding was not currently a key constraint on delivering on its current information commitments. On the assumption that to provide the additional information on hospitals required in our remedy, as well as developing the consultant information, a new information organization would need £2 million funding per year—which we believe would represent an upper end estimate—this represents an incremental cost to the sector of £0.9 million per year. In addition, we were told that the costs of providing an ICD 10 diagnostic code would be

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<sup>1103</sup> Coronary artery bypass graft.

<sup>1104</sup> *Sixth National Adult Cardiac Surgical Database Report 2008: Demonstrating quality.*

<sup>1105</sup> For example, see: [www.bmj.com/content/346/bmj.f1139](http://www.bmj.com/content/346/bmj.f1139).

<sup>1106</sup> For example, we found that the median catchment area (defined as the area from which the hospital drew 80 per cent of its patients) was 17.5 miles.

<sup>1107</sup> Laing & Buisson (2012) indicates that the private-patient-only hospital market was worth £3.54 billion in 2011, whilst total specialists' fees were £1.59 billion, giving a total of £5.13 billion. This total is likely to be slightly overstated as the specialists' fees figures may include some fees paid to consultants to treat NHS patients in private facilities.

around £6.90 per patient.<sup>1108</sup> PHIN told us that it currently collected data on 650,000 private patient admissions per year and that it thought this would be likely to increase to around 700,000 with more complete market coverage. On this basis, the incremental cost of ICD 10 coding would be approximately £4.8 million per year.

11.589 Finally, PHIN indicated that the collection and analysis of PROMs style information would cost between £10 and £20 per patient. Assuming that this information was collected on approximately 5 per cent of private patient episodes, which we consider is likely to be an upper estimate, this suggests that the associated costs would be between £0.35 million and £0.7 million per year.

11.590 In addition, we believe that there will be some, relatively minor, costs incurred by private hospitals, professional bodies, consultants and others in terms of staff time involved in gathering the performance data specified in this remedy, contributing expertise in terms of designing performance measures, checking data and setting up/adjusting IT systems to support this initiative. As the information collected by the private hospital groups would contain consultants' GMC numbers and would allow for the production of all the performance measures on consultants, we concluded that there were no incremental costs for consultants in publishing these performance measures.

11.591 As discussed in paragraph 11.586, it is not possible to provide a robust quantification of the likely improvements in the quality of healthcare services that would result from the greater availability of performance information on hospitals and consultants. However, the data publication exercise undertaken by the cardiothoracic surgeons demonstrated that improvements can be highly significant in terms of the quality of services provided. The incremental costs of providing the information set out above are between £6.0 million and £6.5 million per year, which equates to less than 0.2 per cent of the total annual expenditure on private healthcare services and a cost of around £8.50 to £9.25 per private patient.<sup>1109</sup>

11.592 Some of the parties suggested that the collection and publication of consultant performance information might discourage consultants from agreeing to treat the most difficult cases. However, we thought that this concern could largely be addressed by risk-adjusting the data (which is facilitated by the collection of diagnostic coding), hence we did not think that there would be a detrimental impact on the sickest patients as a result of consultants refusing to treat them. We note that this is an ongoing process and represents a challenge for the broader healthcare sector, including the NHS, as well.

11.593 We concluded, therefore, that the likely costs of collecting and disseminating performance information on both consultants and hospitals were relatively low in comparison with the potential quality and price improvements that could be expected as a direct result of publishing this information. We considered whether there was any alternative, less onerous means of remedying the AEC identified. AXA PPP suggested that the CC should require the private hospital operators and insurers to work together to look further at the issue of data collection and quality assessment to agree what data should be collected to benefit consumers. We observed that our consultation on this remedy has sought views from across the industry on what information would be useful to patients and that we have carefully considered the potential costs and benefits, agreeing to more limited data collection where parties expressed concerns about the cost and/or usefulness of certain types of data. We

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<sup>1108</sup> £5.75 plus VAT.

<sup>1109</sup> See footnote 1107. We note that the estimate of cost per patient does not imply that these costs would necessarily be passed through to patients.

were concerned that AXA PPP's proposed approach would delay the collection and publication of meaningful performance information for patients and that it risked compromising the effectiveness of the remedy by permitting a potentially much more limited set of information to be provided. As a result, we concluded that AXA PPP's proposed remedy would not be effective in addressing the AEC and consequent detrimental effects identified. We did not receive any other suggested alternatives to our proposed remedy, nor did we see any other way of achieving the aim of improving the availability of meaningful hospital and consultant performance information.

11.594 On this basis, we concluded that our remedy was both effective and proportionate as a means to address the AEC arising from insufficient publicly available performance information.

### *Information on consultant fees*

#### *Introduction*

11.595 In Section 10 we identified a lack of information on consultant fees as a feature that gives rise to an AEC in the provision of privately-funded healthcare services by consultants.

### *Consultant fee information*

11.596 In the provisional decision on remedies, we proposed to implement an order on private hospitals to require, as a condition of granting practising privileges, that (all) consultants provide fee information to patients using standard letter templates provided by the hospital. Hospital operators would be responsible for ensuring that consultants complied with this requirement and would be required to implement this remedy within six months of our final report.

11.597 We proposed that, at the time of confirming initial or subsequent outpatient consultation appointments, consultants should be required to provide patients with written (email or post) confirmation of:

- (a) the cost of the outpatient consultation, which may be a range<sup>1110</sup> but, if so, should be accompanied by an explanation of the factors that will determine the actual fee level within the range;
- (b) details of any financial interests (shareholdings or otherwise) that the consultant holds in medical facilities or equipment;<sup>1111</sup>
- (c) a list of all insurers which recognize the consultant;
- (d) a note encouraging insured patients to check the terms of their policy with their insurer, with particular reference to the level of outpatient cover they have; and
- (e) the address of the information organization website, with a statement that this contains useful information on hospital and consultant quality information.

11.598 Furthermore, we proposed that, at the time of recommending or confirming further treatment, whether surgical, medical or other, the consultant should provide patients with written confirmation of:

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<sup>1110</sup> A range may be appropriate, for example when the length of the outpatient consultation may vary significantly.

<sup>1111</sup> See our remedy on clinician incentives.

(a) their diagnoses; and

(b) a fee quote for the specific treatment (pathway) recommended for the patient. For insured patients, this should either include all consultant fees that will be charged separately from the hospital fee (surgeon, anaesthetist, radiologist etc), or should include contact details for any specialists whose fees are not included in the quote provided. For self-pay patients, the letter should set out the package price of the treatment.<sup>1112</sup> These quotes should clearly state which services are included in the fee and which are excluded, such as unforeseeable complications. Where there are treatment options and the appropriate option can only be selected during surgery, these should be set out clearly with the associated fees.<sup>1113</sup>

11.599 In the provisional decision on remedies, we proposed that all private hospital operators in the UK be covered by this requirement. These operators would be required to provide consultants with appropriate template letters meeting the requirements set out above. The information required in each type of communication should be set out in either a letter or email to the patient in a clearly legible font.<sup>1114</sup> The first letter should be sent at the same time as the outpatient consultation is confirmed with the patient. The second letter should be sent within 48 hours of the final outpatient consultation and prior to surgery (whichever is sooner).

11.600 We proposed to enforce the remedy by requiring the private hospital groups to ask every patient undergoing treatment<sup>1115</sup> at their facilities to confirm (by signing) that they received the above information in advance. Where consultants did not provide sufficient information to patients, it would be the hospitals' responsibility to enforce compliance.

11.601 Finally, we would require consultants practising privately to submit information on their outpatient consultation fees and standard procedure fees to the information organization by December 2016 for publication on its website alongside information on consultant performance. This fee information should cover all procedures undertaken by the consultant in his/her private practice.

#### *How the proposed remedy addressed the AEC we provisionally found*

11.602 The proposed remedy addressed the AEC that we had provisionally identified by increasing patients' awareness of the fees that they were likely to incur in seeking private treatment, whether they were covered by insurance or were self-pay patients, and thereby ensure that patients were able to make informed choices between consultants. As a result, when combined with additional information on consultant quality,<sup>1116</sup> this remedy would allow patients to choose consultants that offer the best value healthcare, stimulating competition between consultants to attract patients.

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<sup>1112</sup> For self-pay patients, it would not be necessary to provide a breakdown of the components of the package price provided all elements are guaranteed within the fee.

<sup>1113</sup> For example, where an investigative procedure could be followed by surgery immediately if a problem were found but with no further action if there were no problem, the letter should set out these options and the associated fees for all treating medical specialists.

<sup>1114</sup> For example, size 11 or larger, Arial or Times New Roman font.

<sup>1115</sup> 'Treatment' comprises any inpatient, day-case or outpatient procedure, including diagnostic tests and scans.

<sup>1116</sup> This is addressed in our performance information remedy.

### *What the parties told us*

- *Insurers*

11.603 Bupa welcomed the proposed remedy on consultant fees and recommended that it should be put into place as quickly as possible following the investigation. Bupa suggested that:

- (a) a single standardized letter template should be used by all private hospital operators to ensure that consistent information was provided to patients; and
- (b) the letter should clearly state the patient's rights and who to contact if they wished to file a complaint.<sup>1117</sup>

11.604 AXA PPP put forward the view that this remedy should be as comprehensive as possible, ensuring that patients had fee information before they saw or required the services of a specialist. AXA PPP argued that it would not be difficult for consultants to provide information on all fees in advance and not just outpatient consultations. It put forward the view that the remedy as currently formulated would not be of significant benefit to patients as they would not be able to easily compare procedure charges across consultants. AXA PPP suggested that the remedy should require specialists to make prices publicly available for their most common procedures on the hospital's website and their own, as well as identifying the anaesthetic fees for the same procedures.<sup>1118</sup>

11.605 Aviva supported our proposed remedy on the provision of consultant fee information, stating that the requirement that hospitals ensured that consultants complied with this remedy by making it a condition of gaining and retaining admitting privileges was an appropriate compliance mechanism.<sup>1119</sup>

11.606 PruHealth expressed concerns that the publication of consultant fees, in the absence of accompanying performance or quality information, was likely to result in increases as lower-priced consultants increased their rates in line with higher-priced consultants.<sup>1120</sup> Both Bupa and Aviva also had some concerns about this sort of 'race to the top'.<sup>1121</sup>

11.607 WPA suggested that consultants should provide full details of their fees to patients in advance.

- *Private hospital operators*

11.608 BMI expressed its support for this remedy and stated that, while it was important that the details of fees were as clear and specific as possible, where a range of fees might apply, this should also be explicit for patients. BMI also suggested that the CC require consultants to confirm their compliance with the remedy as part of the GMC's revalidation process.<sup>1122</sup>

11.609 HCA stated that it was willing to support the remedy as it considered that increased fee transparency was important for patients. HCA highlighted that the remedy, as

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<sup>1117</sup> Bupa response to provisional decision on remedies, paragraph 6.23.

<sup>1118</sup> AXA PPP response to provisional decision on remedies, paragraphs 90–92.

<sup>1119</sup> Aviva response to the provisional decision on remedies, section 5.

<sup>1120</sup> PruHealth response to Remedies Notice, section 6.

<sup>1121</sup> Aviva response to Remedies Notice, section 6, and Bupa response to Remedies Notice, paragraph 6.41.

<sup>1122</sup> BMI response to provisional decision on remedies, paragraphs 5.13 & 5.14.



formulated in the provisional decision on remedies, would be onerous for all hospital operators, but particularly for HCA given the number of high-acuity procedures undertaken by consultants at its hospitals and the fact that, even after full diagnosis, the risk of complications require details of and costs for multiple treatment pathways associated with these types of treatments to be set out.

11.610 HCA requested clarity on (a) whether the hospitals would face a penalty if consultants did not comply with the remedy, (b) who should bear the financial risk if there turned out to be a shortfall between the fees quoted and those incurred, particularly where the treatment pathway is not clear at the time of providing the information, and (c) whether self-pay package prices needed to be broken into their constituent parts in the same way as for insured patients.<sup>1123</sup>

11.611 Spire supported a remedy designed to increase fee transparency and highlighted a number of practical considerations, including:

- (a) The timing of the provision of information would make it awkward for patients to move to a different consultant if they were not happy with the fees quoted, as this would generally require them to go back to their GP and obtain another referral letter.
- (b) Not all outpatient consultations took place in hospitals and therefore hospital operators could not oversee consultant compliance with the remedy in all cases.
- (c) In the case where a patient needed multiple outpatient appointments, Spire suggested that it should not be necessary to inform the patient of fees in each case.<sup>1124</sup>

11.612 Nuffield noted that its consultants generally performed around five core procedures, with relatively standardized fees for these procedures such that 'we believe the average fee charged for a consultant's five most common procedures to be the most appropriate data to publish'.<sup>1125</sup>

11.613 Circle argued that the remedy should cover all private GPs, clinics and NHS PPUs in order to ensure parity between operators and the effectiveness of the remedy.<sup>1126</sup>

- *Others*

11.614 The IDF agreed that patients should be kept informed of fees in advance in an open and transparent manner. It believed that consultants should be free to set their own fees and to charge top-up fees if they so wished, but should not leave patients with unexpected shortfalls. However, it raised a number of concerns regarding publishing fees on websites, questioning whether all patients should be charged the same fee for consultations regardless of length, complexity or funder. The IDF also noted that publishing fees could have an inflationary effect, as most doctors would not wish to be seen as the 'cheapest'.<sup>1127</sup>

11.615 FIPO argued that the publication of consultant fees would be ineffective in allowing patients to 'shop around' in the absence of additional provisions to ensure that:

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<sup>1123</sup> [HCA response to provisional decision on remedies](#), section 12.

<sup>1124</sup> [Spire response to provisional decision on remedies](#), paragraphs 6.1 & 6.2.

<sup>1125</sup> [Nuffield response to Remedies Notice](#), paragraphs 7.1–7.3.

<sup>1126</sup> [Circle response to provisional decision on remedies](#).

<sup>1127</sup> [IDF response to Remedies Notice](#).



- (a) patients are able to use the benefits to which they are entitled under the terms of their insurance policy to visit their preferred consultants, paying top-up fees if they wish;
- (b) an obligation on the part of the insurers not to deregister consultants on the basis that the consultant charged in excess of the level of fees that the insurer was willing to reimburse; and
- (c) insurers were prevented from imposing a fee cap as a condition for recognition of new consultants.

11.616 FIPO also suggested that the insurers should be required to publish details of the benefits that they offered to policyholders for different procedures.<sup>1128</sup>

11.617 The OFT highlighted that the remedy should take into account the risk of anticompetitive information exchange or price collusion as the result of increasing the transparency of pricing information.<sup>1129</sup>

### *Our assessment of the consultant fee information remedy*

#### *Design considerations*

11.618 The principal aim of the CC in requiring consultants to provide additional information on their fees is to ensure that patients are adequately informed regarding the costs of private healthcare, thereby stimulating competition on price between consultants by facilitating shopping around by patients. In addition, greater transparency on the full costs of consultant services should avoid patients facing unexpected expenses.<sup>1130</sup> In this context, we have considered what information should be communicated to the customer, when this information would be most helpful, and in which format the information should be conveyed.

11.619 The main proposal received from the parties was that the remedy should require patients to be given more information on procedure fees prior to attending an outpatient consultation. We agreed with the underlying rationale for requiring this, which was to maximize the ability of patients to choose between consultants on price since they would have information on the (consultant) costs of all stages of their potential treatment in advance of the first outpatient visit. We share AXA PPP's concern that once a patient has attended an outpatient consultation with one consultant, they are likely to face switching costs in moving to another consultant since it is not possible to compare a number of quotes quickly and easily.<sup>1131</sup> However, in response to our Remedies Notice, we received a large number of submissions questioning the practicality of such a remedy and the potential for list prices to mislead patients in advance of a detailed diagnosis. We considered that the requirement for consultants to submit information on their fees for publication by the IO would go some way to addressing these concerns, although the fees published would be list prices rather than a specific quote and could, therefore, legitimately be expected to vary. We thought, however, that this was inevitable given the highly-personalized nature of the service provided.

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<sup>1128</sup> [FIPO response to provisional decision on remedies](#), paragraphs 2.1–2.29.

<sup>1129</sup> [OFT response to provisional decision on remedies](#), remedy 6.

<sup>1130</sup> This occurs when a patient's medical insurance will only meet a part of the total cost of treatment and the patient was not aware of this in advance.

<sup>1131</sup> These switching costs are both financial—incurring a second initial outpatient consultation fee—and psychological, ie the feeling of being discourteous or disloyal by changing consultant after establishing a rapport with them.

- 11.620 As regards the format of the fee information, given the range and potential complexity of the information provided<sup>1132</sup> and the potentially vulnerable state of a patient, we consider that it should be provided to patients in writing<sup>1133</sup> to ensure clarity in terms of which services are covered in each element of the fee information and which are not.
- 11.621 We took into account the concerns of the OFT regarding the potential for collusion over fees if these were to be made public. We thought that this could be best addressed by requiring that consultants published their 'list prices' on the information organization's website, leaving them free to charge more or less than this level as they considered appropriate and preventing consultants from knowing the actual prices charged by their competitors to patients.
- 11.622 We considered Bupa's suggestion that the standard letter should make clear how patients could complain if they felt that they had cause to do so. While we thought that this suggestion was reasonable in many respects, we noted that the requirement for private hospitals to check that patients admitted to their facilities had been given appropriate fee information would fully address the AEC we identified. We have not found that a lack of information on the procedure that patients need to follow in order to complain is a feature giving rise to an AEC in this market and therefore did not need to be included in any remedial action.
- 11.623 We considered the concern, raised by Spire, that not all outpatient consultations took place in hospitals and therefore the PHPs could not oversee consultant compliance with the remedy in all cases. We recognized that the PHPs could not oversee compliance for activities that took place outside their facilities. We thought that it was important for the effectiveness of the remedy that all patients were provided with the information specified by this remedy. We decided, therefore, to put a direct obligation on all consultants practising privately in the UK to provide the information as set out above and not just on the hospital operators to ensure that the consultants did so when practising at their facilities. In this case, we thought that individual consultants should determine the format of their letters subject to including all the information set out above.
- 11.624 We considered whether it would be necessary to put in place a means of enforcing the remedy for non-hospital appointments. We noted that where an outpatient consultation was followed by treatment, enforcement could still take place via the private hospital operators. We thought that it would be complex and potentially costly to set up a separate enforcement scheme for patients who followed a treatment pathway that did not include any hospital visits and that this cost was unlikely to be justified by the relatively small number of patients who were likely to be affected (given our assumption that most consultants would wish to comply with our order without external enforcement).
- 11.625 We concluded, therefore, that the information remedy set out in the provisional decision on remedies was appropriately designed and that the only change that was necessary to ensure its effectiveness was to direct the Order requiring the provision of the relevant information at consultants as well as hospitals.

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<sup>1132</sup> For example, a fee quote may include surgery, with the associated surgeon's and anaesthetist's fees, as well as follow-up consultations and outpatient treatments.

<sup>1133</sup> We considered that this requirement would be met via either paper or email correspondence.

## **Effectiveness**

- 11.626 The majority of respondents to both the Remedies Notice and the provisional decision on remedies did not question the effectiveness of providing additional information to patients on consultant fees in terms of helping patients to 'shop around' or in preventing the occurrence of unexpected shortfalls and therefore remedying the AEC arising from a lack of information on consultant fees.
- 11.627 As discussed in paragraph 11.619, we thought that the requirement to publish consultant fees, both for outpatient consultations and for the procedures undertaken by the consultant in private practice, on the IO's website would address AXA PPP's concerns regarding the completeness of the information available to patients and the extent that it could be used to 'shop around'. We recognize that by delaying the publication of information, this reduces the immediate effectiveness of the remedy. However, we considered that this delay was justified by the need to ensure that consultant performance information (being collected by the information organization) was made available at the same time as price information, which should avoid a potential race to the top in which price is seen to be a proxy for quality and consultants therefore push up their fees.
- 11.628 We considered FIPO's argument that without the ability of consultants to set their fees without interference from the insurers and for patients to freely choose a consultant, there could not be effective competition on price among consultants. We did not agree with this argument. We did not find that the price caps imposed by the insurers were forcing consultants out of private practice at the aggregate level,<sup>1134</sup> which would have reduced the choices available to patients, nor did we see any reason that insurers should not sell restricted policies provided it was made clear to patients what they were purchasing.<sup>1135</sup> Patients who preferred to have a free choice of consultants could choose a different insurer or different policy to give themselves this option. For those patients who had chosen restricted policies, we thought that even in a context where insurers set an upper limit to the fees charged to their policyholders, consultants could still compete below this level on price, making the remedy effective.
- 11.629 We recognize that many patients, particularly those with medical insurance, may choose not to 'shop around' even if given the information with which to do so. However, we consider that for this remedy to be effective, it is only necessary for a relatively small but significant proportion of private patients to do so as switching on the part of these patients would provide consultants with an incentive to compete on fees. The survey undertaken by GfK for the CC indicated that 29 per cent of patients cited whether or not their PMI would cover a consultant's fees to be an important reason for choosing a particular consultant. In addition, 10 per cent of patients surveyed indicated that they would be prepared to travel further for a lower-cost consultant or a lower-cost hospital. Finally, insured patients subject to a policy excess may need to pay some or all of the consultant's fee for a first appointment themselves, thus increasing the incentive to shop-around. This suggests that a small but significant proportion of patients are price sensitive, at least to the extent that they may be required to make co-payments and hence are likely to use this information to shop around. Furthermore, insured patients, if provided with the consultant fee information suggested, would be better placed to determine the extent of their policy coverage as early as possible in the process and make choices in terms of whether to claim on their policy and/or pay any additional fees not reimbursed by their insurer.

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<sup>1134</sup> See section 7.

<sup>1135</sup> See Section 7.

11.630 We concluded, therefore, that this remedy was likely to be effective in ensuring that patients had sufficient information on the prices charged by consultants. In conjunction with our remedy on providing consultant quality information, we reasoned that this remedy would be effective in allowing patients to make meaningful choices between consultants based on value (ie both quality and price) of the healthcare services provided by consultants.

### *Proportionality*

11.631 The two principal benefits that we foresee resulting from this remedy are competition among consultants on the basis of price and the avoidance of unexpected costs for patients. In the case of the former, we note that total specialist fees charged for treating private patients in the UK were £1,585 million in 2011. Although it is not possible to quantify what proportion of this cost may be saved by patients as a result of increased competition between consultants, even a 1 per cent average decline in prices is equivalent to a £15.9 million decline in costs annually, some of which will be saved directly by patients, via lower shortfalls, top-ups and/or co-payments, and some by the PMIs, at least a proportion of which we would expect to be passed through to patients in lower insurance premiums.<sup>1136</sup> While the extent to which PMIs would pass through lower costs will depend on the level of competition in the insurance market, economic theory suggests that this will range from full to partial depending on the nature of competition in providing private medical insurance.

11.632 We considered that the following costs would be associated with implementing this information remedy:

- (a) staff time at the hospitals adjusting the terms of practising privileges agreements, producing template letters for consultants and checking with patients that they had received them; and
- (b) consultant time in collating information on the fees and contact details of the other specialists with whom they work, as well as creating their own template letters for non-hospital appointments.

11.633 We expect that the majority of these costs would be associated with setting up the letter templates and collating information on specialists' fees initially, with relatively minor ongoing costs of maintaining up-to-date lists. We understand that, in accordance with guidance from the relevant professional bodies as well as a previous MMC recommendation,<sup>1137</sup> many consultants already provide some fee information to patients. For these consultants, we believe that this remedy would represent minimal additional time, with the introduction of template letters potentially representing a time saving. For consultants who are not currently providing written fee information, this remedy will represent an additional administrative task, although we would not expect the time involved to exceed a few minutes of consultant time per patient, assuming secretarial support.

11.634 None of the parties which commented on this remedy made any suggestions regarding a less onerous remedy and we did not consider that there was an alternative and less onerous means of ensuring that patients obtained the necessary information on consultant fees. We concluded, therefore, that this was the least onerous effective remedy to the AEC arising from lack of information on consultant fees.

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<sup>1136</sup> See paragraphs 11.166–11.172 above.

<sup>1137</sup> MMC inquiry into [The supply of Private Medical Services](#), 1994, paragraph 11.164.

11.635 We concluded that the costs associated with this remedy are immaterial and likely to be outweighed by the benefits to patients in enabling them to make more effective choices, especially in the longer term, when both consultant performance and fee information is made available. As a result, we consider that this remedy is proportionate in addressing the AEC that we have identified arising as a result of the lack of information available to patients on consultant fees.

## 12. Remedies we have decided not to pursue

### *Introduction*

- 12.1 In this section we describe remedies that we have considered but do not intend to pursue, setting out our reasons. We first set out our reasoning as regards remedy options that we included in our provisional decision on remedies and our Remedies Notice. We then describe remedies proposed to us by parties which we do not intend to pursue, setting out our reasons.

### *Remedies contained in our provisional decision on remedies*

#### *Remedy 1 (divestitures–BMI)*

- 12.2 As set out in section 10, we have identified two structural features in the provision of privately-funded healthcare by hospitals:

- (a) high barriers to entry and expansion for private hospitals; and
- (b) weak competitive constraints in many local markets, including central London;

which lead to higher prices:

- (c) of inpatient and some day-case and outpatient hospital services to self-pay patients at private hospitals in local markets subject to weak competitive constraints including central London; and
- (d) being charged across the range of treatments by HCA to PMIs for insured patients in central London;

and together these structural features give rise to AECs in the markets for private hospital services.<sup>1138</sup>

- 12.3 At the time of publishing our provisional decision on remedies, we had provisionally found that the structural features identified gave rise to AECs in respect of insured patients treated by HCA, BMI and Spire. However, our final finding is that the structural features identified do not give rise to any AECs in relation to insured patients outside central London (see Section 10).
- 12.4 The provisional decision on remedies proposed divestiture to remedy the AECs arising from these structural features. In this section, we summarize the divestiture proposals for BMI hospitals set out in the provisional decision on remedies, the further analysis that we have undertaken on the effectiveness and proportionality of these proposed divestitures, taking into account our revised finding as to the scope of the AECs and our reasons for now concluding that divestiture of BMI hospital would not be a proportionate remedy.

#### *Background*

- 12.5 In the provisional decision on remedies, we set out in detail our approach to determining which hospitals should be divested in order to effectively and proportionately

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<sup>1138</sup> See Section 10.

remedy the AECs arising from weak competitive constraints and high barriers to entry and expansion. This approach comprised:

- (a) systematically identifying areas in which the co-ownership of private hospitals increased the market power of the private hospital operators and, therefore, areas where divestiture was likely to be effective in increasing the competitive constraints acting on local hospitals;<sup>1139</sup>
- (b) conducting detailed assessments of the likely effectiveness of divestitures on the basis of local market dynamics; and
- (c) carrying out a cost-benefit analysis in order to assess the proportionality of divestiture remedies.<sup>1140</sup>

12.6 In the first instance, we reasoned that divestitures were likely to be effective where a single private hospital operator owned more than one hospital with overlapping catchment areas in a single area (which we characterized as a ‘cluster’) and which faced weak competitive constraints in that area.<sup>1141</sup> We specified that the level of overlap required for us to consider that two hospitals were in a ‘cluster’ was a network effect on LOCI of 0.2 or more, ie the impact of co-ownership was to increase the operator’s total weighted average market share in the catchment area of one (or more) of the hospitals by 20 percentage points or more.<sup>1142</sup> We used the network effect on LOCI of 0.2 as a filter to identify the areas in which divestiture was likely to be effective in increasing competitive constraints.

12.7 Our next step was to conduct a detailed assessment of the likely effectiveness of divestiture in increasing competitive constraints in each area, taking into account the following factors:

- (a) the range of medical services (specialties) offered by the hospitals, including the availability and type of ICU;
- (b) the proximity of the hospital of concern to other hospitals both owned by the same operator and by competing facilities;
- (c) the catchment areas of the hospitals in areas of concern, the extent to which co-owned hospitals have overlapping catchment areas and the location of insured patients;
- (d) the mix of patients treated at the hospitals, ie insured, self-pay, overseas and NHS; and
- (e) the size and capacity of the hospitals in the relevant local area.

12.8 We considered the extent to which a divestiture would increase the ability of the PMIs to switch recognition away from the hospital operator with the cluster in a given area and towards competing facilities. In general, we concluded that divestiture would be effective where it permitted PMIs to do this in situations in which they had not previously been able to do so and would be ineffective otherwise. In one case,<sup>1143</sup> we considered that a divestiture that allowed PMIs to switch a larger proportion—but not

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<sup>1139</sup> See Appendix 6.4.

<sup>1140</sup> See Appendix 11.2.

<sup>1141</sup> We assessed the level of local competitive constraints on the basis of local assessments of each area. See Appendix 6.7.

<sup>1142</sup> See Appendix 6.4.

<sup>1143</sup> This was the case of BMI Clementine Churchill and BMI Bishops Wood.

all—of their volumes away from the BMI hospital in the area, was also likely to be effective. Generally, we concluded that divestiture would not be effective in increasing competitive constraints where only self-pay patients were likely to benefit *and* where there were few such patients located in the catchment areas of the cluster hospitals.<sup>1144</sup>

- 12.9 In the case of Spire, we identified one cluster area (Leeds) where Spire faced weak competitive constraints but our detailed assessment of this area indicated that the divestiture of any of its hospitals was unlikely to be effective in increasing the competitive constraints on the group. In the case of BMI, we identified nine cluster areas where BMI faced weak competitive constraints and, following a detailed local assessment, we concluded that it would be both effective and proportionate to require the divestiture of the following seven hospitals:

- (a) either the Clementine Churchill or Bishops Wood;
- (b) either Kings Oak or Cavell;
- (c) either Chiltern or Shelburne;
- (d) Chelsfield Park and either Sloane or Shirley Oaks;
- (e) either Saxon Clinic or Three Shires; and
- (f) Highfield.

*Revised analysis*

- 12.10 In light of our final findings which no longer find that the structural features identified give rise to any AECs in relation to insured patients other than those treated by HCA in central London, we have reassessed the effectiveness and proportionality of the divestiture remedy as it applied to BMI. In particular, we revised our calculations of the NPV of divestitures, taking into account the fact that our final finding indicated that only self-pay patients could reasonably be assumed to benefit from the impact of an increase in competitive constraints on prices as a result of the divestiture remedies.
- 12.11 We reasoned that our approach to assessing the likely price benefits of divestiture, which was based on the change in LOCI in each area, provided a means of quantifying the likely effectiveness of a remedy.<sup>1145</sup> It also provided an important input into our proportionality assessment for which we estimated the NPV of the costs and benefits of divestiture. Therefore, we recalculated the price benefits of the seven BMI divestitures, on the assumption that the increase in competition would only affect the prices paid by self-pay patients. For the purposes of this analysis, we assumed that BMI would choose the smallest divestiture package in terms of the profits generated by the hospitals.

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<sup>1144</sup> We took this approach when considering the effectiveness of divesting Methley (Spire) Carrick Glen and/or King's Park (BMI), and Lincoln or Park (BMI).

<sup>1145</sup> See Appendix 11.2.



TABLE 12.1 Impact of divestitures on total private patient revenues\*

Hospital divested	Revenue reduction, £'000	
	All private patients Inpatient & day case (Base case)	Self-pay patients Inpatient & day case (Base case)
BMI Bishops Wood	[X]	[X]
BMI Shelburne	[X]	[X]
BMI Cavell	[X]	[X]
BMI Chelsfield Park & BMI Shirley Oaks	[X]	[X]
BMI Saxon Clinic	[X]	[X]
BMI Highfield	[X]	[X]

Source: CC analysis.

\*The figures in this table do not take into account (net-off) the impact of the information remedies.

Note: These estimates are based on FY11 revenue figures, including the split between inpatient, day-case and outpatient treatment and NHS- and privately-funded patients. The range of values shows the impact of a change in price of between 3 and 4 per cent for a 20 percentage point change in market share. This is based on a LOCI coefficient of 0.1717 in our price-concentration analysis.

- 12.12 In the provisional decision on remedies, we estimated that the total annual price benefit to patients would be between £4.4 million and £5.9 million per year. On the basis that only self-pay revenues would be affected by the divestiture remedy, we estimate that the total price benefits would be between £0.7 million and £1 million per year.
- 12.13 We considered that these values were likely to be conservative since they did not take into account any quality improvements that would be likely to arise as the result of increasing competition for self-pay patients in these local areas, the benefits of which would be likely to accrue to all patients treated at these facilities and not just self-pay patients.
- 12.14 On the other hand, we noted that these price effects were calculated without taking into account the potential impact that our information remedies might have on self-pay prices. BMI argued that if these remedies were effective, they would change the relationship between price and concentration over time, increasing competition. We agree that the information remedies are likely to increase the competitive constraints acting on both private hospitals and consultants by allowing patients to compare quality across operators, thereby encouraging patients to travel further for better quality treatment. We reasoned that, by increasing patients' willingness to travel and therefore the catchment areas of hospitals, this remedy could be expected to exert downward pressure on prices. While we recognized that there was significant uncertainty regarding the quantification of such an effect, we thought that it was not unreasonable to assume that a 1 per cent decline in prices might result from this effect (over time). To the extent that this effect reduced the incremental impact of the divestiture remedy, which we considered to be a reasonable assumption, we concluded that it should be taken into account when estimating the NPV of a divestiture remedy. On the basis that BMI hospitals in the areas in which divestitures were proposed generated approximately £[X] million of self-pay revenues per year (inpatient and day case), we estimate that the information remedies could reduce the impact of divestitures by around £[X] per year.
- 12.15 BMI set out a number of additional costs and reductions in benefit which it argued should be taken into account in our assessment. We concluded that it was not necessary to come to a view on these costs as we determined that, on the basis, of our original assumptions, divestiture was no longer a proportionate remedy, particularly once we took into account the potential impact of the information remedies.

12.16 In Table 12.2, we set out our recalculation of the NPV of the divestiture remedy assuming that only self-pay revenues (inpatient and day case) are affected by the divestiture remedy. All the other assumptions used in the provisional decision on remedies are maintained in this analysis, ie one-off costs of £[REDACTED] million,<sup>1146</sup> either zero or £[REDACTED] million annual loss of economies of scale, and a price change of 3.5 per cent in response to a change in LOCI of 0.2. The first column shows our NPV estimates, as set out in the provisional decision on remedies. The second column shows the same analysis updated to reflect a situation in which the only impact of divestiture is on the prices paid by self-pay patients. The third column sets out the results of adjusting the self-pay analysis to take into account the likely impact of our information remedies. In effect, this shows the incremental NPV of the divestiture remedy. As such, the results in the third column form our current preferred estimate or 'base case' of the NPV of the divestiture of seven of BMI's hospitals.

TABLE 12.2 NPV associated with proposed divestiture packages

£ million					
	NPV of divestitures All private patients		NPV of divestitures Self-pay patients		NPV of divestitures (including impact of information remedies) Self-pay patients
	Downside case	Base case	Downside case	Base case	Downside case
					Base case
BMI	19.2	57.0	(26.1)	2.4	(29.4) (1.0)

Source: CC analysis.

Note: The information remedies are assumed to take partial effect in the third year after the divestitures (50 per cent of total impact assumed) and full effect from the fourth year onwards. This reflects the time period over which the information remedies are expected to increase the availability of data on hospital performance and consultant performance and fees for patients.

12.17 This analysis demonstrates that, when we take into account the impact of our other remedies and restrict the price impact such that only self-pay revenues are affected, the divestiture remedies proposed for BMI in the provisional decision on remedies, are likely to generate a negative NPV over a 20-year period, ie the net benefit to patients is likely to be more than offset by the costs to the business. The base case NPV falls from £57 million to –£1.0 million, while the downside case, which takes into account a loss of economies of scale for BMI of £[REDACTED] million per year, falls from £19 million to –£29 million.

12.18 Next, we considered whether the divestiture of any individual BMI hospitals would represent a proportionate remedy. We estimated the NPV of the benefits of each divestiture individually, taking into account the estimated impact of our information remedies (see Table 12.1) and considered how this would compare with the transaction and reorganization costs, as well as the potential loss of economies of scale.

12.19 The figures that we used in our provisional decision on remedies for transaction and reorganization costs were totals assuming the divestiture of all seven hospitals. We reasoned that the reorganization costs would be broadly 'scaleable' in that the divestiture of a single hospital would incur costs of around one-seventh of the level of the divestiture of seven hospitals. On this basis, we assumed that BMI would incur reorganization costs of approximately £[REDACTED] million per hospital. In contrast, we considered it likely that transaction costs would not scale down in proportion to the

<sup>1146</sup> This is comprised of transaction costs of £[REDACTED] million and reorganization costs of £[REDACTED] million.

number of hospitals sold. We reasoned that BMI would incur around 30 per cent of the total costs for each hospital sold, ie £[REDACTED] million.

TABLE 12.3 NPV of the price benefits of individual hospital divestitures

Divestiture	NPV of benefits £m	Total transaction and reorganisation costs £m	NPV of divestiture remedy
Bishops Wood	[REDACTED]	[REDACTED]	[REDACTED]
Shelburne	[REDACTED]	[REDACTED]	[REDACTED]
Cavell	[REDACTED]	[REDACTED]	[REDACTED]
Chelsfield & Shirley Oaks	[REDACTED]	[REDACTED]	[REDACTED]
Saxon Clinic	[REDACTED]	[REDACTED]	[REDACTED]
Highfield	[REDACTED]	[REDACTED]	[REDACTED]

Source: CC analysis.

12.20 As the transaction and reorganization costs are incurred at the beginning of the period, these can be directly compared with the NPV of the price benefits. This analysis demonstrates that, in each case, the costs of the divestiture remedy would outweigh the benefits, on our base case assumptions. We note that this analysis does not take into account the loss of any potential economies of scale as a result of the divestiture remedy, ie it does not show the downside case.

12.21 We concluded, therefore, that while divestitures in cluster areas were likely to be effective in increasing the competitive constraints acting on BMI hospitals in the relevant local areas vis-à-vis self-pay patients, the divestitures proposed in the provisional decision on remedies would not be proportionate on this basis. Therefore, we will not require BMI to make any divestitures of assets.

### **Remedies contained in our Remedies Notice**

#### ***Remedy 2 (constraints on private medical insurer/private healthcare provider contract terms ('tying and bundling'))***

12.22 In our provisional findings we identified two structural features in the provision of privately-funded healthcare by hospitals:

- (a) high barriers to entry and expansion for private hospitals; and
- (b) weak competitive constraints in many local markets, including central London.

12.23 We provisionally concluded that, together, these features gave rise to AECs in the markets for hospital services that were likely to lead to higher prices for self-pay patients in certain local markets and to higher prices for insured patients for treatment by those hospital operators (HCA, BMI and Spire) that had market power in negotiations with PMIs.<sup>1147</sup>

12.24 Our Remedies Notice included divestitures which would address the AECs effectively in certain local areas but would not do so in what we characterized as single and duopoly areas.

12.25 We therefore set out in our Remedies Notice a behavioural remedy (Remedy 2), that sought to address two specific types of conduct that PMIs had said that hospital

<sup>1147</sup> Provisional findings, paragraphs 6.248(a) & 10.3.

operators engaged in: raising, or threatening to raise, prices across all their hospitals in the event that a PMI de-recognized one of its hospitals or recognized a rival on its network, which was addressed by the proposed remedy 2(a); and declining to offer or price its hospitals separately, which was addressed by the proposed remedy 2(b). For convenience, we referred to these practices collectively as ‘tying and bundling.’

- 12.26 As is set out in paragraph 10.6, our final decision is that there is no AEC arising from weak competitive constraints and high barriers to entry in respect of insured patients for treatment by hospital operators located outside central London. However, our view of the AECs as regards insured patients in central London remains unchanged. We have decided that these features lead to higher prices being charged by HCA to PMIs across a range of treatments for insured patients in central London.<sup>1148</sup> We set out here why we have decided not to adopt this remedy in preference to a divestiture remedy in central London. We first set out the views of parties to the original proposals.

*What parties told us*

- 12.27 The majority of parties making submissions told us that this remedy was not practicable and would be ineffective in addressing the AEC we had provisionally identified.
- 12.28 Bupa told us that it did not think that, on its own, either (a) or (b) would be effective since neither addressed the source of the hospital groups’ market power: their ‘must-have’ hospitals. It said also that the remedy was liable to be circumvented and could give rise to unintended consequences.
- 12.29 Regarding Remedy 2(a), Bupa said that hospital groups could adopt a variety of tactics other than across-the-board price increases to punish PMIs and it gave us some examples of these.
- 12.30 In addition, Bupa said that this remedy risked giving rise to unintended consequences. It said that hospitals might be deterred from offering price/volume discounts at all if they were locked into a price no matter what changes in volume took place. In addition, hospital operators might decline to participate in new, for instance, low-cost networks in response to PMIs using the rights that this remedy would confer on them.
- 12.31 It said that were price increases to be reviewed by, for example, the CMA to establish whether they were punitive, this would take time and create uncertainty. It therefore believed that, should this remedy be introduced, then a dedicated, standing private healthcare adjudicator should be put in place, whose general overheads should be funded by the main hospital groups but that the costs of specific disputes should be borne by the parties concerned.
- 12.32 Bupa said that Remedy 2(b) would not be effective, as hospitals would raise prices above their previous levels in areas where they faced little or no competition since the high barriers to entry that the CC had found would make it unlikely that a new rival would enter the local market. Bupa said that hospital groups could also circumvent the remedy by delaying agreement for terms on ‘must-have’ hospitals until they had been agreed for hospitals facing competition.

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<sup>1148</sup> Paragraph 10.5 above.

- 12.33 AXA PPP said that Remedy 2(a) would prevent automatic, contractual and immediate price increases but would not prevent higher prices in the next contract round. It did not consider Remedy 2(b) to be either necessary or practicable.
- 12.34 PruHealth said the intentions of the remedy were welcome but thought that the requirement of Remedy 2(b) to negotiate prices for each hospital separately and independently would be onerous in resource terms.
- 12.35 Aviva said that Remedy 2(a) was liable to circumvention as hospitals could negotiate volume discount terms which incentivized recognition of all their hospitals. It also said that the remedy would require significant levels of monitoring and enforcement.
- 12.36 WPA said that Remedy 2(a) would only be relevant to a PMI that offered a restricted network of hospitals, which it did not. It said that it would be unlikely that many insurers would wish to take on the administrative burden of negotiating all prices separately and that no-one would wish to have 30+ sets of individual prices and charge masters each running to several thousand items.
- 12.37 Simplyhealth said that tariffs were likely to be related to volumes in the longer term and, as a result, the effect of Remedy 2(a) was likely to be limited. It said that Remedy 2(b) would not be practical other than for the two largest PMIs and might therefore make them even more powerful.
- 12.38 HCA said that if Remedy 2(a) had the effect of preventing a hospital from varying its prices on the basis of patient volume changes, this was the equivalent to a price control. HCA noted that, given the cost structure of hospitals, changes in patient volumes affected costs across its hospitals. It said that a remedy which prevented the parties from reviewing or renegotiating contract prices in response to changes in volume would not be reasonable or proportionate and would incentivize the parties to enter into shorter-term contracts to guard against mid-contract changes in network composition. Further, HCA said that as it operated its hospitals within the same geographical area, London, and on a network basis, whereby the patient journey might encompass several hospital facilities, a fall in volume at one of its hospitals would affect take-up in another. It would therefore be legitimate for HCA to reflect this in its pricing.
- 12.39 HCA said that the CC's aims were more likely to be achieved by tackling contractual restrictions which directly related to and restricted a PMI's power to change its network. These included:
- (a) exclusivity provisions: exclusivity clauses specifically restricting a PMI from changing its network policy for the duration of the contract;
  - (b) non-recognition clauses: any clauses which required a PMI not to recognize designated competitors; and
  - (c) targeted price clauses: clauses which triggered a price review expressly because of a PMI's recognition of a designated competitor.
- 12.40 HCA said that the remedy as set out by the CC would prohibit particular types of contract provision and parties must therefore be given a full and fair opportunity to, where appropriate, terminate any existing arrangements or to allow current fixed contracts to expire and renegotiate new contracts.
- 12.41 In its response to the provisional decision on remedies, HCA said that the CC's reasons for dismissing any prohibition of these types of contractual restriction were

not convincing. It said it would be relatively straightforward to devise a prohibition of contractual restrictions which restricted the PMI's right to appoint competing hospitals onto its network. There was no reason why this should required adjudication or a dispute resolution process, as the CC had argued, since it could be left to any parties affected by these restrictions to take civil action to enforce the remedy.

- 12.42 On Remedy 2(b) HCA said that it was able to price its hospitals individually, but that PMIs had not previously sought to negotiate terms of access to HCA's hospitals on an individual basis. HCA told us that it operated a network of facilities in London and that there were cost and other benefits in PMIs accessing the whole network of hospitals for their subscribers. HCA said that there would be serious implications for its network and the financial viability of its hospitals if either Bupa or AXA PPP de-listed individual HCA hospitals.

- *The Office of Fair Trading*

- 12.43 The OFT expressed concerns that Remedy 2(a) would require a high degree of monitoring, especially given the difficulty or impossibility of devising some bright-line definitions, such as when a hospital's price rise might be attributed to a change in a PMI's network arrangements. It suggested that an adjudication mechanism be created on the lines of those created in the local bus services market and in groceries for the Groceries Supply Code of Practice (GSCOP). The OFT also suggested that, in the case of Remedy 2(b), compliance monitoring might be made easier if PMI and hospital agreements co-terminated

*Our assessment*

- *Design considerations*

- 12.44 We considered whether the two variants of the remedy that we set out in the Remedies Notice:
- (a) would comprehensively address the forms of conduct that a hospital operator could potentially adopt to exploit its local market power in negotiations with PMIs;
  - (b) were subject to circumvention risks; and
  - (c) would not be effective unless accompanied by other measures.
- 12.45 We considered these arguments for each variant in turn.

- *Remedy 2(a)*

- 12.46 We agreed with the OFT that bright-line definitions would be difficult or impossible to devise in order to distinguish price increases which were cost-reflective from those which were not. We also recognized that there may be other, and perhaps many other forms of conduct designed to achieve the same end which may be even less straightforward to identify. For example, it would be very difficult to demonstrate, in the context of a civil action or remedy enforcement, that HCA had threatened not to participate in a new PMI network in order to deter the PMI from recognizing a rival, or de-recognizing one of its hospitals, rather than that it had declined to participate simply because the parties had failed to agree mutually satisfactory commercial terms.

12.47 We concluded that, as a consequence, monitoring and enforcing this remedy would be complex and expensive, that the risk of circumvention was high and that remedy 2(a) would not be an effective remedy to the AECs.

- *Remedy 2(b)*

12.48 It was put to us in response to our Remedies Notice, and thus in relation to all hospital operators, not just HCA, that Remedy 2(b) would permit, and be likely to result in, hospital operators raising prices substantially above current levels at hospitals where:

- (a) there was little or no local competition; and

- (b) it was important for a PMI to include that hospital in its network. This might, for example, be because the hospital was important to a corporate client with a concentration of employees in the hospital's catchment area.

12.49 Parties submitted that, as we had provisionally concluded that high barriers to entry existed in the private healthcare market, it would be unsafe to rely on the threat of entry to deter price increases. Consequently, it was put to us that this remedy was unlikely to be effective unless accompanied by additional measures.

12.50 Our findings did not distinguish between HCA's hospitals on the grounds set out in paragraph 12.48, but even had they done so the same objection would hold true: since we had found that there were barriers to entry in central London, HCA would not be deterred from raising prices by the threat of entry or expansion.

12.51 We therefore concluded that remedy 2(b) would not be effective in addressing the AECs that we had found.

- *Additional measures*

12.52 We next considered whether remedy 2 could be modified to make it effective through the adoption of additional measures.

12.53 One feature of behavioural remedies, as compared with structural measures, is that they do not address the underlying causes of a lack of rivalry as certainly. Consequently, while behavioural measures may address particular forms of conduct which have been identified during an investigation and through which market power is manifested, they may fail to address other, including new, forms of conduct through which a firm may exercise its market power. As noted in our Guidelines for Market Investigations:

Circumvention risks—It is possible that other adverse forms of behaviour may arise if particular forms of behaviour are restricted. For example, if prices are controlled a firm may reduce product quality. To avoid or reduce these risks, behavioural measures will generally need to deal with all the likely substantial forms in which enhanced market power may be applied.<sup>1149</sup>

12.54 We considered first whether the number or type of forms of conduct specified by our remedy was comprehensive or should be extended. Other forms of conduct of which

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<sup>1149</sup> [Guidelines for market investigations: Their role, procedures, assessment and remedies, CC3 \(revised\)](#), April 2013.

we were aware, some of which were specifically cited by parties as illustrating market power, included:

- (a) non-recognition clauses: any clauses which require the PMI not to recognize designated competitors;
- (b) targeted price clauses: clauses which trigger a price review expressly because of a PMI's recognition of a hospital's competitor; and
- (c) 'most-favoured nation' type contract terms: preventing a PMI from favouring a competitor through its patient 'guidance' processes or excluding it from a network.

12.55 We considered whether these specific forms of conduct, and perhaps others, should be included within the scope of the remedy. We also considered whether it would be desirable to include a more general measure in the remedy, prohibiting conduct and contract terms which could be deemed to illustrate the exercise of market power.

- *Additional conduct/contract terms*

12.56 We reasoned that while more, specific forms of conduct or contract terms could be added to the remedy it was unlikely that the list would be comprehensive, or remain so for long, as HCA could adopt other tactics which we had not foreseen through which to exploit its market power. We therefore considered whether a more general prohibition of conduct/contract terms could be included which would prevent circumvention through the adoption of certain tactics in the future.

- *A general anti-circumvention measure*

12.57 We thought that it was inevitable that any general anti-circumvention measure would be more likely than a specific prohibition to give rise to disputes between HCA and PMIs as to whether particular forms of conduct or contract terms fell within the scope of the remedy. Various parties, including the OFT, had suggested that to be effective the remedy, even as originally envisaged, would need to be accompanied by a mechanism or process for resolving such disputes.

12.58 We noted that dispute adjudication mechanisms had been adopted as remedies in several CC market or merger inquiries. We also noted that relationships between PMIs and hospital operators appeared, generally, to be characterized by distrust, disagreements and disputes. We therefore considered whether an adjudication process or dispute resolution process would be necessary or appropriate to ensure the effectiveness of this remedy.

12.59 In previous remedies where we have required the creation of an adjudicator we have in most cases been able to specify fairly precisely what conduct was considered to fall within the scope of the measure. We thought that, although it would be feasible to require an adjudicator to decide whether particular contract terms fell within the scope of a specific prohibition, it would go beyond the scope of an adjudicator to do so when the criteria for adjudication were less precise and where it might be necessary to exercise a high degree of judgement. We noted earlier, for example, that HCA could adopt a very wide range of tactics to deter a PMI from recognizing a competitor, including refusal to participate in a new network being contemplated by an insurer. It would be extremely difficult to demonstrate that such conduct was linked to a dispute over hospital recognition. We thought that ruling in such cases



would more closely resemble the role of a regulator than an adjudicator. We consider this issue further when we discuss proportionality.

- *Conclusions on effectiveness*

- 12.60 In order for Remedy 2 to be fully effective it would be necessary to identify a comprehensive and specific list of forms of conduct or contract terms to be prohibited. However, we considered it likely that HCA would be able to circumvent the remedy by adopting additional forms of conduct that would fall outside the scope of the remedy and which we had not foreseen or specified. To address such circumvention risks it would be necessary to adopt a more general anti-circumvention measure together with a mechanism to resolve disputes between HCA and PMIs, including as to whether a particular form of conduct was prohibited under the remedy.
- 12.61 We considered that distinguishing between an inappropriate exercise of market power and legitimate cost-reflective volume discounts in this market was likely to be complex and that monitoring and adjudication would be costly. In addition, a general anti-circumvention measure might detract from the clarity needed in a fully effective remedy.
- 12.62 We concluded that Remedy 2 was unlikely to be effective in addressing the relevant AECs in central London.

### *Remedy 8 (price controls)*

- 12.63 In our Remedies Notice, we said that we had considered the imposition of price controls (Remedy 8) on hospitals which had market power in insured and/or self-pay sectors, but that we did not intend to pursue this remedy further unless we were provided with evidence or reasoning to the contrary. We have decided that weak competitive constraints faced by private hospitals in a number of local areas across the UK including central London, combined with barriers to entry and expansion, leads to higher prices in those areas for inpatient treatments as well as for some day-patient and outpatient treatments for self-pay patients, and that weak competitive constraints faced by HCA in central London, combined with barriers to entry and expansion, leads to higher prices being charged by HCA to PMIs across the range of treatments for insured patients in Central London.<sup>1150</sup> We said that, while price control would be an effective remedy, it would not address the root cause of the problem, and we thought it would be complex to design and update, would require some form of adjudication in the event of disputes and would be likely to have unintended consequences, such as deterring new entry.
- 12.64 Bupa told us that, in its opinion, our proposed remedies did not provide effective constraint on hospitals in the significant majority of single/duopoly areas.<sup>1151</sup> It did not believe that either the threat of entry or that of a CMA investigation provided any meaningful constraint on the pricing of incumbent operators. It suggested that we should consider price control for approximately [X] single hospitals (and targeted divestment of certain duopoly hospitals, in addition to our proposed divestments in cluster areas). Bupa estimated a ballpark figure of £[X] million a year of private spend (by self-pay patients and PMIs) in these [X] hospitals and thought that this would likely outweigh the cost of enforcing a price control regime (which should be

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<sup>1150</sup> Paragraph 6.495.

<sup>1151</sup> [Bupa response to Remedies Notice](#), paragraphs 4.41–4.48.

funded by the hospitals subject to the control). It said that a price control mechanism could either involve a bottom-up costing of services to construct a tariff or the price of treatments could be linked/pegged to the average price of similar treatments at a like-for-like hospital in competitive local markets, correcting for geographic cost differentials.

12.65 No other major party to the inquiry favoured imposition of a price control regime.

12.66 In our guidance,<sup>1152</sup> we say that:

this type of behavioural remedy can be complex to implement and monitor, given informational asymmetries between the parties and the authorities and the associated risk of circumvention. There is also a risk that such controls create market distortions, particularly if they are kept in place over a long period. Ensuring that measures to control outcomes remain fit for purpose in the light of market developments may involve costs for monitoring and enforcement agencies as well as for the parties subject to them.

12.67 We were concerned that, given the large number of different treatments and procedures in existence, a price control regime would be very difficult and costly to set up in this market (whether in the form of a reference tariff or by comparison to charges levied by similar hospitals) and to update, to take account of both the introduction of new treatments and procedures, and movements in costs over time. We were also concerned that price controls may be vulnerable to circumvention, in that hospitals subject to such a cap would be incentivized to reduce the quality of the service they provide. Further, we thought that the existence of price caps may generate distortion risks over time by discouraging innovation and the introduction of new and better treatments and procedures. They would also discourage new entry into an area subject to a capping regime, unless the potential new entrant could be certain that the fact of its entry would result in the removal of price caps in that area. There is at present no private healthcare industry regulator and the imposition of this remedy would require one to be created to administer and update the price-capping regime and adjudicate on disputes.

12.68 We considered that, while price caps might appear to address the immediate customer detriment in single hospital areas, the cost of setting up and administering such a regime would be considerable and, over time, would result in customer detriment through distortions creating lower quality of service and reduced innovation. We therefore decided that a price-capping regime would not be effective in the long term, and would not be proportionate.

## ***Other remedy proposals***

### ***Background***

12.69 In their submissions to us, some of the PMIs proposed other potential remedies to deal with the AECs that we had provisionally found. In this section, we describe each proposal briefly and then go on to say why, after careful consideration, we decided not to adopt it.

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<sup>1152</sup> CC3, [paragraph 378](#).

## AXA PPP

- 12.70 AXA PPP suggested<sup>1153</sup> that, for a prescribed list of tests, scans and drugs (to be defined), PMIs should have the right to make their own procurement arrangements from wholesalers of these products and services. Hospitals and clinics would then be required either to charge at the same rate as that secured by the PMI or to make use of the separate wholesale arrangement made by the insurer. It said that this would very significantly increase the level of price competition for these services to the benefit of the consumer. It considered that a remedy of this kind would also have significant positive effect where the remedy of divestment, in particular outside of London, had been identified as being less effective since it would drive more competition, even in those areas which remain served by a single hospital or duopoly.
- 12.71 While AXA PPP's proposal does address a clear area of concern, we considered that, as with Remedy 2(b), this remedy would be unlikely to address the AECs comprehensively. First, we thought that it would be extremely complex to monitor and enforce since disputes would inevitably arise over the comparability of the alternative sources found by PMIs to be cheaper than HCA. Some form of adjudication process would have to be created as part of the remedy and this would add to its cost. Secondly, we considered the proposed remedy presented circumvention risks. If it were introduced, and HCA incurred a loss of revenue as a result, we considered that they would not find it difficult to make up the lost revenue in other ways, for example by cross-subsidy from other types of charges not subject to this remedy. Finally, we were concerned about the practicability of sending patients elsewhere for scans, for example, if HCA declined to match a PMI's negotiated rate. We therefore decided that AXA PPP's proposed remedy would not be effective.

## PruHealth

- 12.72 PruHealth was concerned about hospital charge-master items that mainly focused on the level of mark-ups for drugs and appliances/prosthesis, and the pricing of pathology and radiology tests.<sup>1154</sup> It proposed that a reference price (not a tariff) should be defined for pathology and radiology tests. The reference price would be based on the purchase cost of the equipment/reagent, leasing/depreciation costs over seven years, insurance and maintenance costs, and a defined utilization rate.
- 12.73 PruHealth also proposed the creation of reference prices for consultants' fees, based on average costs, time and pricing.<sup>1155</sup> Consultants could vary their fees above or below the reference rate, but the existence of a reference rate would at least provide self-pay patients with a basis from which to judge the reasonableness of the fees they were being asked to pay.
- 12.74 We considered that PruHealth's first proposal came close to price regulation, and would in effect require the definition of a regulated asset base for each hospital and the creation of a new regulator to enforce the remedy. We concluded that the complexity and expense of monitoring and enforcing such a remedy would make it disproportionate to the harm it was intended to address.
- 12.75 We considered that PruHealth's second proposal also came close to price regulation, and would remove an element of competition among consultants. Although

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<sup>1153</sup> AXA PPP response to provisional findings and Remedies Notice, paragraph 1.27ff.

<sup>1154</sup> PruHealth response to Remedies Notice, 'Alternative solutions to price control'.

<sup>1155</sup> *ibid*, 'Consultant fees'.

analogous regulations exist in other countries (such as the USA, South Africa and Canada) in respect of their public health provision, we concluded that setting (and regularly renegotiating) reference prices for each and every procedure that a consultant undertakes would be complex and time-consuming, and disproportionate to the harm the remedy was intended to address.

#### *Aviva*

- 12.76 In order to make price negotiations more transparent and to provide PMIs with visibility over how hospital operators price for the services they offer, Aviva suggested that the CC consider a remedy that required hospital operators to present, for a basket of common procedures, an open-book analysis of their proposed charges.<sup>1156</sup>
- 12.77 Aviva also said that consultants should share the reasons why they were recommending one hospital over another with the customer or consumer.
- 12.78 We considered that open-book pricing worked best in a context where the participants viewed each other essentially as partners and the atmosphere generally was one of cooperation rather than confrontation. We concluded that the introduction of open-book pricing to negotiations between hospital operators and PMIs would inevitably lead to disputes (for example, over how prices were calculated), requiring the creation of an adjudicator to resolve them. We also concluded that, to the extent that hospital groups have market power, open-book pricing might not necessarily lead to lower prices, as that power would enable them to charge significant mark-ups over cost if they so wished.
- 12.79 We considered that our remedy on clinician incentives which, inter alia, requires consultants to disclose any financial interest they may have in a hospital, was sufficient in terms of transparency. We did not consider Aviva's second proposal, that consultants should also provide a detailed set of reasons for recommending one hospital over another, was necessary or appropriate.

#### *WPA*

- 12.80 WPA told us that hospital operators should be obliged to publish clear and transparent pricing information as to the cost of treatment. It said such prices should be readily available for all to view and compare at any time. Hospitals should be only able to discount from such a tariff by up to a certain level of discount, say 20 per cent (to reflect special terms or quantum). It said that, in this way, other providers, insurers and self-pay patients would be able to ascertain the likely cost of treatment within a reasonable tolerance level. WPA thought that this would create a requirement to offer realistic pricing which, in conjunction with the other remedies proposed by the CC, would bring in real competition.
- 12.81 We considered that limiting a hospital provider's ability to discount (eg for volume) would not foster rivalry between PMIs and would favour smaller PMIs at the expense of larger ones. We found that it did not take sufficient account of the high level of fixed costs incurred by hospital operators, which made it rational for them to offer larger discounts to customers from whom they anticipated higher volumes of patients, for example by being included on a particular network. We also considered that the transparency objective of the proposal (ie that patients should be able to

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<sup>1156</sup> [Aviva response to provisional findings and Remedies Notice](#), paragraph 8.

ascertain the likely cost of their treatment) could be met by our remedy requiring that consultants disclose to patients both their own fees for consultations and the indicative cost (both surgical and anaesthetic) for the most likely procedures, whether medical or surgical, undertaken by the consultant. We were reluctant to interfere, without a very good reason, in the freedom of hospital operators and PMIs to negotiate prices between themselves and, as the transparency objective vis-à-vis patients could be met by our requirement for the disclosure of fees, we did not consider that the imposition of an obligation to publish tariff prices was proportionate or appropriate.

### **13. Our package of remedies: summary, effectiveness and proportionality**

#### ***Introduction and summary***

13.1 Our analysis of the options and the decisions set out in Section 11 has led us to adopt a package of remedies which is summarized as follows:

##### ***(a) Divestiture of hospitals in central London***

- (i) An order or undertakings requiring HCA to divest either the Wellington Hospital, together with the Wellington Hospital Platinum Medical Centre (PMC), or the London Bridge, together with the Princess Grace Hospital to a suitable purchaser or purchasers, approved by the CMA, through an effective divestiture process. Implementation is to be carried out in accordance with the following requirements: Suitable purchasers will be independent of HCA, will not raise further competitive or regulatory concerns and will have appropriate financial resources, expertise, assets and business plans to enable the divested hospital(s) to compete effectively in the central London market.
- (ii) HCA will be required to divest the hospital or hospitals within a period of [X] from the date of acceptance of undertakings or the making of an order. HCA will be required to appoint a monitoring trustee, approved by the CMA, to monitor the divestiture process and compliance with the Undertakings or Order on the CMA's behalf. The CMA will have power to require the appointment of an independent divestiture trustee if HCA has not entered into a binding agreement to divest to a purchaser approved by the CMA within the specified divestiture period.
- (iii) To assist effective divestiture, the CMA will require PMI insurers to roll over their existing contractual terms with the divested hospital(s) for a period of up to 18 months.

##### ***(b) Review of PPU arrangements with private hospital operators***

An Order ensuring that arrangements between NHS trusts and private hospital operators for the operation or management of a PPU will be capable of review by the CMA. The Order will enable the CMA to prohibit those arrangements found not to meet a competition test as set out by the CMA.

##### ***(c) Restrictions on clinician incentive schemes***

An order prohibiting private hospital operators from offering inducements to procure referring clinicians to give preference to their hospitals and to disclose publicly other arrangements with clinicians as required by the CMA. The Order will also place limitations on equity participation by referring clinicians in private hospitals or associated JVs.

##### ***(d) Publishing information on healthcare facility and consultant performance***

An order requiring healthcare facility operators to provide private inpatient and daycase patient episode data to an Information Organization (IO) which will make it publicly available. The nature of the data and the format in which it is published by the IO will be approved by the CMA.

*(e) Providing consultant fee information*

An Order requiring healthcare facility operators and consultants to publish consultant fee information on their and the IO's websites and otherwise as required by the CMA.

13.2 In the remainder of this section we:

- (a) describe how the proposed package of remedies addresses the AECs and the resulting customer detriment which we have found (see paragraphs 13.3 to 13.10);
- (b) consider the effectiveness of the package, including the extent to which the remedies are capable of effective implementation, monitoring and enforcement, the timescale over which they will take effect and the coherence of the remedies package taken as a whole (see paragraphs 13.11 to 13.31);
- (c) consider the effect of any action on RCBs (see paragraphs 13.32 to 13.35); and
- (d) assess the proportionality of the package (see paragraphs 13.36 to 13.47).

***How the proposed package of remedies addresses the AECs***

13.3 We discussed the rationale of each element of the remedies package in Section 11. In this section we set out how the remedies package works as a whole to remedy the AECs and the resulting customer detriment that we have found. We first discuss the individual contribution of each element of the package of remedies to remedying the AECs and then the synergies that exist between the elements.

*Contribution of individual elements of the remedy package*

13.4 The individual contributions of each element of the package are described in detail in Section 11. We summarize these here for convenience:

- The divestiture that we will require HCA to make will introduce greater rivalry between private hospital operators in central London. Central London accounts for around 30 per cent of all private hospital revenue in the UK, around 37 per cent of revenue generated by inpatient care and 22 per cent of overnight beds in private hospitals in the UK. We consider that the proposed divestiture will enable substantially greater rivalry on price, quality and range. We consider it likely that new ownership of the Wellington (including PMC) or London Bridge and Princess Grace hospitals will result in lower prices together with the maintenance or improvement of standards at these hospitals given the importance of high-quality care in attracting and retaining corporate clients, patients and consultants.
- Our remedy permitting a review by the CMA of arrangements between private hospital operators facing weak competitive constraints and NHS trusts for the operation of a local PPU addresses the high barriers to entry and weak competitive constraints in many local areas including central London, which are features of this market. The remedy will open up local markets by enabling alternative providers to enter or expand in areas in which hospitals currently face weak competitive constraints.
- Our remedy addressing consultant incentive schemes aims to restrict and make transparent the means by which private hospital operators reward clinicians for

referrals which may prevent, restrict or distort competition between hospitals through the introduction of non-clinical considerations into the choice of hospitals or treatments. The remedy relies in some cases on the enforcement of a total ban by the CMA and in others on the disclosure of benefits in cash or kind being provided and the basis on which these are made available by private hospital operators to clinicians.

- Our information remedies together comprise a package of measures that will make it easier for patients, GPs and consultants to assess a private medical facility's suitability in terms of quality and price, via a set of disclosure requirements. They will also allow patients and GPs to assess a consultant's suitability in terms of their qualifications, experience and performance and the fees they charge. We consider that this remedy will address the AECs both by facilitating patient choice on the basis of quality and price, thus rewarding better-performing facilities and consultants, and by stimulating private healthcare facilities and consultants to compete for patients on the basis of published performance data based on objective quality criteria.

### *Synergies between remedies*

13.5 In broad terms our remedies address the AECs by:

- (a) reducing local concentration (through divestiture and by lowering barriers where feasible); and
- (b) enabling rivalry between private hospitals on the basis of the price and quality of the services they provide to patients rather than, for example, the benefits they provide to clinicians, and enabling rivalry between consultants on the basis of the price and quality of the services they provide to patients.

13.6 We do not consider that any of our remedies would, in isolation, address the AECs comprehensively. For example, our restrictions on clinician incentives would not on their own solve the AECs in central London as, absent the divestitures that we are requiring HCA to make, private medical insurers and self-pay patients would still have few outside options. The divestitures in central London, however, would similarly not address the AECs comprehensively if our information remedies did not permit patients to compare the price and quality of private healthcare facilities and consultants.

13.7 Our remedy permitting the review of arrangements between private hospital operators and NHS trusts for the operation of PPUs is intended to facilitate new entry which the incumbent operator could, absent our remedy placing restrictions on the provision of clinician incentives delay or make more expensive through the use of inducements to consultants to refer patients to or to commission tests at its facilities, rather than at the PPU.

13.8 Even if our first three remedies were adopted, competition between private hospitals and between consultants could be stifled by the lack of objective, relevant and comparative information on the quality of the services that they provide and the fees charged by consultants. Our information remedies are designed to work alongside the other remedies in the package to assist corporate and individual customers to select appropriate private healthcare facilities and consultants. We consider that the provision of such information will also increase rivalry between private hospitals and between consultants by encouraging patients to, for example, weigh travel time to a private hospital against the quality of care provided. In the absence of adequate information on service quality, patients may naturally tend to choose their nearest



hospital and/or a consultant who is familiar to their GP. If they were aware of quality differences between private hospitals and between consultants they may be willing to travel further to use their services. Our information remedies thus work together with our structural measures.

### *Conclusion on how the proposed remedy package addresses the AECs*

- 13.9 In summary, we consider that our remedies will work in combination to increase rivalry between providers of privately funded healthcare services and this increased rivalry will benefit patients.
- 13.10 We now turn to our assessment of the effectiveness of our proposed remedy package.

### ***The effectiveness of the remedies package***

- 13.11 Our assessment of the effectiveness of our remedy package focused on the following factors:
- (a) the means by which the remedies would be implemented, monitored and enforced;
  - (b) the timescale over which our remedies would have effect;
  - (c) the consistency of our remedies with other regulatory regimes; and
  - (d) the coherence of our remedies as a package.

### *Implementation, monitoring and enforcement*

- 13.12 In developing our remedy options we considered how each of them could best be implemented, monitored and enforced and our reasoning and conclusions are set out for each remedy in Section 11.
- 13.13 As we intend to take action ourselves, rather than make a recommendation to others to take action, we considered whether we should seek undertakings from the relevant parties or make an order. We took into account the extent to which our proposed remedies fell within our order-making powers as well as the practicalities of negotiating undertakings with the number of parties from which it would be necessary to seek undertakings.
- 13.14 In accordance with our guidance, where it appeared that a proposed remedy fell within our order-making powers, we considered whether the way our remedies were intended to operate and their implications would be clear to the persons to which they were directed and to other interested persons, including sectoral regulators and the CMA.<sup>1157</sup>
- 13.15 We considered the cost and complexity of monitoring and enforcing our remedies. Where options appeared to exist, as with our remedy on the management of PPUs, between Monitor and the CMA, we considered which body would be the most appropriate to implement, monitor and enforce a remedy or whether a new body would need to be created to do so.

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<sup>1157</sup> CC3, paragraph 334.

- 13.16 Based on the above considerations and our detailed assessment of each remedy set out in Section 11, we concluded that our remedies package was capable of effective implementation, monitoring and enforcement.

### *Timescale over which our remedies will have effect*

- 13.17 In considering the timescale over which our remedies will have effect, we took account of the time that it is likely to take to implement the remedies and, once implemented, the time it is likely to take for them to have effect.

### *Orders*

- 13.18 We anticipate that the orders through which the majority of our remedies will be implemented will be made within a period of around six months from the publication of our final report, ie by October 2014. This takes into account both the consultation on draft orders and the Government's suggested common commencement dates of 6 April or 1 October for new legislation and regulations, aimed at minimizing burdens on business.<sup>1158</sup>
- 13.19 In the case of divestitures, we intend to allow the parties a maximum period of [X] for the initial divestiture period. The likely end date for the initial divestiture period would thus be [X] though this could be later, if the process of making the order is delayed, or sooner, if the parties commenced the sales process before the order was made. We intend also to require HCA to appoint, as early as is practicable, a monitoring trustee to mitigate asset risk at the hospitals to be sold.
- 13.20 In addition, we are proposing that hospital agreements (on recognition and terms) with private medical insurers are rolled on for a period of 18 months after divestiture, though this period could be shortened by mutual consent, potentially introducing the price reductions that will result from greater rivalry sooner.
- 13.21 As regards clinician incentives, we considered that it would be reasonable to make a distinction between those schemes which will be subject to an outright prohibition and those where current arrangements will need to be modified or abandoned to comply with our order.
- 13.22 In the former case, we concluded that the prohibition should come into effect immediately on implementation of the order since such schemes are the most likely to distort competition between hospitals, have become increasingly rare since the start of the original OFT investigation and subsequently our investigation, and in many cases would appear contrary to the GMC's Good Medical Practice. Other schemes, including those involving shared equity and JVs between private hospital operators and clinicians are liable to take longer to unwind or amend. Given that the CC's intentions will be made clear in its final report, we thought it would be reasonable to set a deadline for this of April 2015, ie six months after the likely making of the order and 12 months after the publication of our final report.
- 13.23 The time that it will take for our information remedies to have effect will vary. It should be possible for the remedy requiring private hospital operators to ensure that consultants with practising rights at their hospitals provide patients with written fee information in advance of treatment to come into effect immediately. The remedies requiring the collection and publication of performance indicators will take longer and will in any

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<sup>1158</sup> [Common Commencement Dates](#), BIS.

case build up gradually. We have set out an indicative timescale for the staged implementation of the private healthcare facilities and consultant performance indicators in Section 11.

### *Consistency with other regulatory regimes*

- 13.24 We considered the consistency of each of our proposed remedies with other relevant regulatory regimes. Our consideration is set out in the description of the individual remedies in Section 11 and we summarize it here.
- 13.25 We considered whether our remedy addressing the management of PPUs was compatible with EU procurement rules. Our view was that EU procurement rules were intended to ensure a competitive tender, leading to best value for money, but that they could not be used to override competition law or merger control, and that NHS trusts would not be required by EU procurement law to make a contract award which gave rise to an AEC (or SLC). We therefore concluded that our remedy was compatible with EU procurement law.
- 13.26 We also considered whether this remedy was consistent with the provisions of merger control, as the test we have proposed for our remedy would be similar to that used in UK merger control, even though arrangements which create a merger situation will be excluded from the scope of the remedy.
- 13.27 We concluded that the test proposed for this remedy would address arrangements which were outside merger control in a way which both remedied the AECs we found and was consistent with the outcome that could be expected had the arrangements been a merger, subject to merger control.
- 13.28 Finally, we considered whether our remedy addressing clinician incentives was inconsistent or incompatible with the GMC's Good Medical Practice. We concluded that, while our remedy is aimed at private hospital operators rather than clinicians, the principles set out in Good Medical Practice are fully compatible and consistent with those of our proposed remedy.

### *Coherence as a package*

- 13.29 As we set out in paragraphs 13.5 to 13.8 the remedies in our package work together to address the AECs that we have found. None in isolation would be fully effective but in combination will address the AECs so far as is reasonable and practicable.

### *Conclusion on effectiveness of remedy package*

- 13.30 Based on the assessment set out in paragraphs 13.11 to 13.29, we concluded that this package of remedies would be effective in addressing the AECs that we have identified and, as a result, would also substantially reduce the customer detriment flowing from the AECs.
- 13.31 We expect the remedy package to have a substantial effect on the AECs and resulting detriment within two to three years, particularly in central London, as a new competitor or competitors emerge(s). Our information remedies, however, may take longer to affect patient and GP behaviour, as they become familiar with them over time. We anticipate, however, that the publication of comparative private healthcare facility and consultant performance information will have a more immediate effect on facilities' managements, corporate clients, private medical insurers and consultants.

## ***Relevant customer benefits***

- 13.32 In deciding the question of remedies, the CC may also have regard to the effect of any action on any RCBs of the feature or features of the market concerned.<sup>1159</sup>
- 13.33 RCBs are limited to benefits to relevant customers in the form of:
- (a) lower prices, higher quality or greater choice of goods and services in any market in the UK; or
  - (b) greater innovation in relation to such goods and services; and
  - (c) a benefit is only an RCB if the CC believes that the benefit:
    - (i) has accrued as a result of the features concerned; and
    - (ii) was or is unlikely to accrue without the features or features concerned.<sup>1160</sup>
- 13.34 We considered whether there were any RCBs that we should take account of in formulating our remedies. In discussing the divestiture remedy, we considered whether proposed divestitures would reduce or extinguish potential RCBs<sup>1161</sup> and concluded that they would be unlikely to do so.
- 13.35 We have not identified, and parties have not claimed there to be, any other RCBs deriving from the features of the market that we have identified that would be extinguished by either one of our remedies in isolation or by the remedies in combination.

## ***Assessment of proportionality***

- 13.36 We evaluated whether this package would be a reasonable and proportionate solution to the AECs by considering the following four questions:
- (a) Is the remedy package effective in achieving its aim?
  - (b) Is the remedies package no more onerous than is necessary to achieve its aim?
  - (c) If there is a choice of remedy packages, is this the least onerous?
  - (d) Does the remedy package produce disadvantages which are disproportionate to the aim?

### ***Is the remedy package effective in achieving its aim?***

- 13.37 As we have set out in paragraph 13.30 above, we consider that this remedy package will be effective in addressing the AECs that we have identified.

### ***Is the remedy package no more onerous than is necessary to achieve its aim?***

- 13.38 We have endeavoured to formulate a package of measures which is effective but no more onerous than is necessary to achieve its aim. We have, for example, not adopted divestiture remedies outside of central London since we considered these

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<sup>1159</sup> The Act, section 134(7).

<sup>1160</sup> CC3, paragraphs 356 & 357.

<sup>1161</sup> See Appendix 11.1.

would be unnecessarily intrusive as the AECs we found extended only to the self-pay sector.

- 13.39 Similarly, in respect of our remedy permitting the review of proposed arrangements for the operation of PPUs by private hospital operators, we have made provision for the CMA to clear those likely to increase local concentration if no other candidate to manage a PPU has emerged.
- 13.40 Where we have adopted intrusive remedies, such as divestiture, we have sought to ensure that no other, less intrusive, remedy was available which would be effective in addressing the AEC. We have also sought to ensure that the divestiture package we have specified is the smallest required to address the AECs although several parties urged us to adopt a much broader divestiture package. In addition, we have given HCA a choice over which hospital(s) to divest. Finally, an effective divestiture process will be designed in such a way as to facilitate HCA receiving a fair market value for the divested business.

*If there is a choice of remedy packages, is this the least onerous?*

- 13.41 We set out in Section 12 remedies that we proposed ourselves or which have been proposed by others that we have considered but have decided not to pursue. As is described there, we considered, for example, price control as a remedy but concluded that less onerous remedies were available. We also consider that all of the remedies in this package are necessary to its effectiveness since they work on aspects of the AECs in different, though complementary, ways. From our analysis and the views of parties to this investigation, it is not apparent that any other package of remedies would be as effective whilst incurring similar or lower costs on the market.

*Does the remedy package produce disadvantages which are disproportionate to the aim?*

- 13.42 We first considered costs that might arise from the remedies in our package.
- 13.43 We invited parties to tell us what costs, to them and others, would be likely to arise as a result of each of our remedies. We considered these submissions carefully and in Section 11 we set out, for each individual remedy, what parties had told us together with our assessment of what they had said.
- 13.44 We estimate that the quantifiable benefits (ie price benefits) to customers likely to arise from the divestiture remedies would be in the range of £30 million to £44 million per year and the annual costs to be between zero and £12.7 million. We estimated that the net present value of our divestiture remedies was, therefore, approximately £298 million over a 20-year period.<sup>1162</sup> In addition, we considered that there were likely to be other benefits in terms of quality and range that would be significant over time but could not be readily quantified.
- 13.45 As set out in paragraphs 11.586 and 11.587, we did not seek to quantify the likely quality benefits arising from our information remedies since we did not consider that these benefits were amenable to robust quantification. However, we judged that these benefits could be expected to be material in light of previous experiences of the

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<sup>1162</sup> This figure refers to our base case estimate. Our downside case indicates an NPV of approximately £117 million, while our upside case indicates an NPV of approximately £474 million.

impact on quality resulting from the publication of performance data. We also considered that the information remedies could serve to exert pressure on hospital and consultant fees by stimulating competition between hospitals across a broader geographic area than is currently the case and by encouraging consultants to compete with one another on fees. We thought that there was significant uncertainty around both the likely magnitude of this effect and the time frame over which it would occur. However, we observed that if it were to reduce total private-patient-only hospital and consultant revenues by 1 per cent, this would result in an annual benefit to patients of around £50 million per year. We estimated the likely incremental costs of our information remedies at between £6 million and £6.5 million a year.

- 13.46 The benefits of remedies in our proposed package other than divestiture and the provision of information are discussed individually in Section 11. We consider that although these benefits are difficult to assess quantitatively, they are likely to be significant over time and substantially in excess of the costs associated with them.

#### *Conclusions on proportionality of remedies package*

- 13.47 We consider that the proposed remedies package fulfils all four conditions for proportionality set out in our guidance.

#### ***Conclusions on the remedy package***

- 13.48 We have decided that we should introduce the package of remedies summarized in paragraph 13.1(a).
- 13.49 In our judgement, this represents as comprehensive a solution as is reasonable and practicable to the AECs and resulting customer detriment that we have found.