

Nuffield Health's response to the Competition Commission's provisional decision on remedies dated 16th January 2014

Introduction

- 0.1 Nuffield Health recognises the significant advances the Competition Commission (CC) has made in its recently published 'provisional decision on remedies' document. As ever, Nuffield welcomes the opportunity to respond to any proposed market intervention, and continues to anticipate further involvement as the CC's provisional remedies are refined.
- 0.2 We appreciate that the CC's investigation is nearing completion, and that material shifts in provisional findings and remedies are less likely at this stage given the maturity of the CC's thinking.
- Nevertheless, Nuffield is using this response to clarify its position on the most important provisional remedies, such that the CC can gauge a more complete view of how its suggested interventions are perceived by the market.
- 0.3 Overall, Nuffield remains aligned with the CC's view regarding the adverse effects on competition (AECs) that its provisional remedies should collectively be seeking to address.
- 0.4 Furthermore, we are encouraged by the CC's progress in developing remedies targeting consultant incentives and fee transparency, PPU, and divestiture in central London.
- 0.5 However, Nuffield is concerned that the CC's approach - both conceptually and methodologically - has too often centred around local markets, without sufficient emphasis on national bargaining dynamics between insurers and hospital operators.
- As insurers represent c.80% of UK patients using privately-funded healthcare services¹, Nuffield is concerned that due consideration is not being paid to whether any of the remedies proposed will materially alter current national bargaining dynamics. It is these negotiations that will determine whether the trend of increasing prices, decreasing consumer surplus, and decreasing PMI penetration can be reversed.
- 0.6 Relatedly, we feel the CC is missing an opportunity to more fully address competitive distortions in the market. For example, the paring back of hospital divestments and the complete removal of any tying and bundling remedy will leave dominant operators with too much market power, which will ultimately be to consumers' detriment. For the avoidance of doubt:

¹ Laing & Buisson Healthcare Market Review 2012-13

- Nuffield believes the divestments proposed in London are sufficient to stimulate competition (subject to supporting behavioural remedies).
- Nuffield believes the divestments proposed across the rest of the UK will not sufficiently address operator leverage over insurers. The CC's own findings state that BMI and Spire *'have market power in negotiations with insurers'*². Given that no divestments for Spire have been identified, the source of their market power will remain, leaving Spire with both the ability and incentive to continue to charge consumers inflated prices going forward. Similarly, while BMI's dominant position in certain local markets will be addressed, they are likely to retain price making power at the national level due to their retention of 'must-have' facilities.
- As Nuffield has stated previously, divestiture (if extensive) can go some way to reducing certain hospital operators' leverage in negotiations with insurers, but will not be enough in itself to solve AECs. A tying and bundling remedy is therefore an essential behavioural constraint required to address operator leverage over insurers more comprehensively. Nuffield was therefore concerned to see that no tying and bundling remedy is being pursued, leaving dominant hospital operators free to tie 'must-haves' to less desirable facilities, circumvent local competition, and negotiate anticompetitive price increases post-divestiture.

0.7 Where the CC has devoted time to reviewing national bargaining dynamics, its quantitative findings from insured pricing analysis (IPA) are being biased by two critical methodological errors³:

1. The CC's cleaned insured pricing dataset does not sufficiently adjust for Nuffield's 'all-inclusive' package price. This package covers preoperative assessments, routine outpatient care, and readmission following complication, the first two of which are conducted in an outpatient setting, and we believe none of these charges are included in competitors' 'episode' prices.
2. The CC has incorrectly controlled for operators' differing average lengths of stay (AvLOS) by procedure. At present, the CC is using this as a proxy for procedural complexity, but AvLOS could equally indicate operational inefficiency. In fact, Nuffield believes that the per-night accommodation charge of its competitors⁴ creates the perverse incentive to keep patients admitted for longer stays. Given the ability of hospitals to control AvLOS⁵, such an adjustment should be avoided by the CC.

0.8 We now offer detailed comments for specific remedies, ordered by importance, in response to developments in the CC's thinking.

0.9 As with previous submissions, if any remedy proposed by the CC is not referenced directly by this response, please do not infer tacit agreement. We reserve the right to comment on any unaddressed remedies at a later time.

² Provisional decision on remedies, 2-1

³ For a more comprehensive review, see Nuffield's data room submission

⁴ Nuffield's package price remains the same regardless of the patient's length of stay

⁵ See market commentary on [enhanced recovery programmes](#), for example

1. Divestiture

- 1.1 Nuffield reaffirms its support for a divestiture remedy, and shares the CC's view that forced disposals can address at source, structural features of the market giving rise to AECs.
- 1.2 Furthermore, we are aligned with the CC's stance on central London, and agree that the presence of a further two market participants will help to drive increased competition on price and quality in the UK's most penetrated PMI market.
- 1.3 Outside of central London however, Nuffield feels the CC is missing the opportunity to more directly address the market power conferred by Spire and BMI's hospital portfolios. Previous CC analysis has identified that '*customer detriment caused by the market power of HCA, BMI and Spire is conservatively estimated within a range of £173m to £193m a year*'⁶.
- This cost is incurred predominantly due to '*higher prices for insured patients for treatment by those hospital operators ... that have market power*'⁷.
- 1.4 The CC's *original* IPA findings resonate with Nuffield's own experience, where we see competitor offerings being charged at materially higher prices despite no discernable difference in quality of treatment or facility.
- [Redacted]
 - [Redacted]
 - [Redacted]
- 1.5 In terms of the CC's revised IPA findings, we refer the CC to our data room submission, where we explain the methodological errors that are clouding operator price comparison at present.
- 1.6 In addressing inflated BMI and Spire pricing, Nuffield offers two main observations on the methodology used to identify divestment targets outside of London:
- A. An undue **focus on local markets** to the detriment of relevant customer benefit (RCB) calculations, and
 - B. The omission of the **impacts of network exclusion** when considering competitive constraints.

⁶ Provisional decision on remedies, paragraph 2

⁷ Ibid.

A. Focus on local markets

- 1.7 In the CC's provisional decision on remedies, 2.59 states that divestments are more effective than behavioural remedies as they '*constrain the market power of the private hospital operators in local areas or in their negotiations with insurers*' (emphasis added).
- However, when reviewing the CC's analysis and divestiture rationale, the focus has been very much on local market impact, which belies the negotiating dynamics between larger hospital operators and insurers
- 1.8 This local market focus is particularly pronounced in the CC's pro-forma EBITDA analysis⁸ and relatedly in the qualitative overlays used to assess the effectiveness of a divestiture package⁹. Nuffield posits that divestitures have the potential to influence prices not just locally, but nationally, as the market power that certain hospital operators leverage during national insurer negotiations is redressed.
- Nuffield agrees that divestiture is likely to have certain positive impacts in local markets, encouraging competition on price and quality. It therefore appears sensible to measure change in local market concentration to derive a likely pricing reduction, especially for self-pay patients.
 - However, the CC's analysis at present does not take full account of the post-divestiture pricing impact at retained group hospitals¹⁰. Given the prevalence of tying 'must-haves' to less attractive group hospitals (either directly or through regional or national volume-tiered pricing), Nuffield believes divestments are likely to have a wider impact on insured prices than solely in a proposed divestment's local market.
 - This further (and as yet unaddressed) relevant customer benefit (RCB) will strengthen the case for divestment at the existing hospitals that have been identified.
 - Furthermore, analysis taking account of this broader impact on insurer-operator negotiations is likely to show that certain 'must-have' divestments are also justified. This would not be on the basis of local market impact (indeed, many of these hospitals are the dominant provider in an asymmetric duopoly), but rather because of the wider impact on insured prices across the divesting party's retained facilities. We strongly encourage the CC to consider this line of argument further.

B. Impact of network exclusion

- 1.9 Nuffield believes that network exclusions should be taken into account when considering the competitive constraints facing hospital operators in local markets.

⁸ Appendix 2.5 to provisional remedies

⁹ Provisional decision on remedies, paragraph 2.94

¹⁰ i.e. no pricing impact is assumed at retained group hospitals that have no catchment overlap with the divested facility

- [Redacted]
- Nuffield therefore encourages the CC to review competitive constraints in local markets in light of network exclusion.

1.10 Relatedly, Nuffield would like to emphasize the fact that insurers are not a neutral party in this investigation. [Redacted]

- [Redacted]
- [Redacted]

1.11 As approval criteria for 'suitable purchasers' of divested facilities are being developed, Nuffield encourages the CC to keep in mind the national bargaining dynamics at play if the divestiture process enabled those hospital groups already found to have market power over insurers to acquire a central London asset. For further information about the distortionary impact of these parties acquiring further market power, we reference our 'must-have threshold' analysis submitted in October '13.

2. Preventing tying and bundling

2.1 As the CC has acknowledged and Nuffield has previously argued, certain hospital operators are likely to retain market power over insurers notwithstanding any identified forced divestments.

- This market power is likely to be more pronounced than Nuffield had previously envisaged given the paring back of the CC's proposed divestments.
- We therefore believe that a remedy addressing the tying of hospitals during insurer negotiations will be central to addressing competitive distortions in the market.

2.2 Nuffield had hoped that a reformulation of the CC's initial proposals around tying and bundling would stop dominant hospital operators from circumventing local competition through the use of national bargaining strategies.

- Whilst the CC has correctly identified the deficiencies of both 2(a) and 2(b)¹¹, Nuffield does not feel that alternatives have been sufficiently explored.
- We would like to draw the CC's attention to our remedies suggestion document submitted on 11th October. While this document was intended to stimulate debate and

¹¹ 2(a) and 2(b) are references to the CC's notice of possible remedies where two variants of a bundling and tying remedy were suggested

present a greater range of ideas to the CC, it appears the CC has stuck rigidly to assessing only variants of a tying and bundling remedy that are similar in composition to 2(a) and 2(b).

- 2.3 Nuffield is concerned that without sufficient behavioural remedies to complement divestiture, tying and bundling will remain a powerful negotiating ploy exploited by dominant hospital operators. [Redacted]

3. Information provision

- 3.1 Nuffield acknowledges that defining what information should be provided for private hospital operators and consultants is a necessarily collaborative exercise. We expect the CC to take this opportunity to refine its provisional remedy through roundtable discussions involving hospitals, insurers, and consultant representatives. In advance of such a meeting, we make the following observations:

- **Choice of metrics**

Nuffield does not believe that all of the metrics identified by the CC in its provisional decision on remedies¹² will necessarily help patients and/or GPs judge hospital and consultant quality. However, we have no objection to their collection and publication, subject to ongoing discussion and refinement with insurers and hospitals operators. The listed metrics represent a useful first step toward addressing informational asymmetries in the market.

- **Reinforcement of current market distortions**

Even if the right data is selected by the CC for publication, if certain anticompetitive behaviours have not been fully addressed by the CC's remedies package, then disseminating data is likely to prove distortionary. For example, Nuffield has no issue with volumes data being published, and in a market where each operator competes on an equal footing for insured and self-pay patients, it is likely to provide useful information to prospective patients. However, in markets where a provider is excluded from one or more insurer networks, consultant drag is 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 these instances, volumes data could drive further concentration in local markets, amplifying the already problematic consultant drag effect.

- **The impact on and the role of insurers**

The CC has proffered that '*information should 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*'.¹³

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

¹² Provisional decision of remedies, paragraph 2.465

¹³ Provisional decision on remedies, paragraph 2.482

outside options available to both insurers and hospital operators during national negotiations. If the CC's remedies fail to address the market power conferred to BMI and Spire through their control of a critical mass of 'must-have' facilities, then insurers will still have little choice but to pay inflated prices to these operators. That is why Nuffield believes the CC's structural divestiture remedy should be taken further than at present.

[Redacted]

It is also worth noting that the results of these types of insurer commissioned research are not currently shared with patients. Moving forward, we believe PHIN might find such data useful when compiling comparative metrics on hospital performance. Furthermore, in order for patients to appreciate the limitations of their policy, and the relative quality of treatment options in local markets, we believe insurers should be obliged to list all local hospitals when asked about referral options, not just those covered by the patient's policy. If this list were supplemented with relevant quality metrics, it would place pressure on PMIs from policyholders to choose the highest quality offering in each market, driving further competition between providers.

4. Consultant incentives

- 4.1 Nuffield is aligned with the CC around the need for consultants to choose a hospital on the basis of the quality of their patient proposition, not the size on any inducements paid in return for patient volumes.
- 4.2 As we have mentioned previously, any distortions to the referral pathway caused by consultant incentives are to the detriment of the consumer, and as such we support a complete ban on direct incentives.
 - In terms of indirect incentives, Nuffield is still weighing up the relevant customer benefits with the costs of intervention, and is engaging in conversation with the Association of Independent Healthcare Organisations (AIHO) at present.
- 4.3 Addressing the details of the CC's proposed ban more directly, Nuffield has the following observations:
 - As we have previously mentioned, the introduction of a de minimis limit appears sensible. Nuffield is currently reviewing the feasibility of the proposed £500 cap, but we agree with the CC's contention that consultants are unlikely to be swayed by such a sum.
 - Nuffield agrees that banning direct incentives is sensible, and that precluding hospitals from offering valued services to consultants does not make sense, providing those services are charged for at fair market rates.

- Nuffield would appreciate greater clarity from the CC around how exactly ‘fair market value’ might be calculated. For example, how might this calculation take account of:
 - a) What constitutes a reasonable volume related discount
 - b) The efficiency savings for hospital operators in offering certain administrative services
- We do not believe the current list of identified incentives is exhaustive, and is at risk of circumvention. Nuffield would gladly discuss omitted incentives with the CC further as this remedy is refined.

5. Further remedies

- 5.1 Nuffield is broadly accepting of remedies addressing PPU expansion and consultant fee information. We would like to point out that the illustrative template for a consultant’s ‘terms of business’ would depend on which insurer the patient is covered by. Both consultants’ and hospitals’ charges vary by insurer, such that the most appropriate data to publish in this regard would be for self-pay patients.

6. Conclusion

- 6.1 In summary, while we believe the divestitures proposed in central London will be effective, further disposals are required [Redacted] across the rest of the UK to address the inflated prices being charged to insurers.
- 6.2 Any divestitures will need supplementary behavioural remedies to address the capacity of dominant hospital operators to tie retained ‘must-have’ facilities to the rest of their portfolio. Only then will competition in local markets deliver better value for money for insurers nationally (either through lower prices or higher quality hospital offerings).
- 6.3 Nuffield similarly supports a remedy that requires hospitals to disseminate better and more comparable information on service and consultant quality. To refine the list of required metrics further we believe the wider industry needs to be consulted in a round table discussion. Nuffield would gladly participate in such a meeting.
- 6.4 And finally, Nuffield remains concerned about the reliability of the CC’s updated IPA results. We believe that both the cleaned insured data set and the methodology used to generate conditional prices need to be refined along the lines set out in Nuffield’s data room submission. Without these adjustments, the CC will not be able to accurately compare nationally agreed prices between operators and insurers on a like-for-like basis – a requirement when assessing the extent of each operator’s market power.