

Private Healthcare Market Study

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

December 2011

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1 EXECUTIVE SUMMARY

- 1.1 The OFT is proposing to refer the market for privately funded healthcare services in the UK (PH) to the Competition Commission (CC) for a market investigation. This report sets out the OFT's reasons for proposing to refer the market and gives interested parties the opportunity to make representations.
- 1.2 The proposal for a market investigation reference follows an in-depth market study of PH by the OFT launched in March 2011.
- 1.3 The market for PH encompasses a range of medical treatments which are privately funded, either directly by patients or through their private medical insurance (PMI) policies, and provided to patients by consultants, medical and clinical professionals in private hospitals, clinics or units (PH facilities).
- 1.4 The total value of the market for acute PH in the UK was approximately £5 billion in 2009. Private hospital and clinics account for the largest part of this figure, generating an estimated £2.83 billion in revenue during 2009. Approximately 80 per cent of acute PH purchases are made through patients' PMI policies. On average 15.8 per cent of people are covered by such a policy in the UK (PMI funded patients).
- 1.5 The market for PH is likely to be an area of growing importance to the UK economy given, in particular, that demand for healthcare services is forecast to grow in line with an expanding and ageing UK population.¹ It may also be increasingly important to the delivery of NHS services as a result of reforms aimed at enabling providers of PH to play a larger role in delivering NHS treatment.
- 1.6 In this context, while the focus of this market study has been on privately funded healthcare for private patients, the OFT has also been aware of the developing linkages between PH and NHS services. It has focused, therefore, on setting out its findings in this report with a view to assisting those bodies with ongoing and new roles in regulating or reviewing healthcare services, including Monitor as the sector regulator

¹ Keynote, *Private Healthcare Market Report*, 2011

for health and the CC which, under legislative proposals, is to review the development of competition in the provision of healthcare services for the purposes of the NHS every seven years.

- 1.7 Through market studies, the OFT is able to undertake a holistic analysis of markets, drawing on its experience and understanding of competition and consumer problems across a wide range of markets. In addition to this, the OFT has developed specific expertise on competition and consumer problems across a range of health markets, including pharmaceuticals and NHS equipment. It has previously considered the PH market in 1999 and in recent mergers decisions in 2010.

Provisional market study findings

- 1.8 The OFT's report provisionally finds a number of features that, individually or in combination, prevent, restrict or distort competition in this market. The OFT considers that these features of the PH market impair the ability of patients, GPs and PMI providers to choose between competing service providers, including new entrants, on the basis of superior quality of services to patients and better value for money. This ultimately may result in patients paying higher prices and receiving lower quality and less efficient services. The features include:
- 1.9 **Information asymmetries:** the OFT considers that there is a shortage of accessible, standardised and comparable information provided to patients, GPs and PMI providers in relation to the quality of PH facilities and of consultants. There also appear to be difficulties for PMI funded patients in assessing the risk of shortfall from particular consultants, whereby a consultant's fees exceed the benefit maxima that the patient's PMI provider will reimburse resulting in the potential for an additional payment by the patient. In addition, for self-pay patients, there are difficulties in easily comparing the prices charged by different PH facilities.
- 1.10 In general, the OFT considers that this shortage of accessible, standardised and comparable information weakens the ability of patients and GPs to drive efficiencies and stimulate enhanced competition between rival PH facilities and between consultants, and may give rise to a dampening of competition in the market overall. The lack of access to information on quality and price for consultants produces a situation

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

- 1.11 **Concentration:** The PH provider market appears to be concentrated at the national level. At the local level there appear to be areas of high concentration, such as areas where there is no alternative fascia PH facility within a 30 minute drivetime of a PH facility (solus PH facilities), and some local markets with PH facilities that PMI providers consider to be 'must have' because they account for a large proportion of PMI providers' spend or are the only PH facility to provide a particular specialism or procedure in the local area.
- 1.12 The existence of solus and 'must have' PH facilities means that PMI providers are dependent on the PH providers that own these facilities in order to provide nationwide coverage for their policyholders.
- 1.13 The size of the larger PMI providers appears to result in a degree of buyer power in that PH providers are, to some extent, dependent on these larger PMI providers for the financial viability of their facilities. However, there may be limits on the PMI providers' ability to exercise their buyer power. Firstly, in order to provide nationwide coverage, PMI providers need to purchase PH in most local markets, including areas with solus and 'must have' PH facilities as described above. Ownership of these facilities appears to give PH providers bargaining leverage over PMI providers. Secondly, since it is GPs that usually recommend consultants to patients, and consultants who then often determine the patient's choice of PH facility, the PMI providers have limited ability currently to direct patients to different PH facilities. Therefore, as the buyer power of the PMI providers appears not to be countervailing, the larger PH providers may have a degree of market power.
- 1.14 Forty-four per cent of anaesthetists are part of an Anaesthetist Group (AG). Prior to, and during the course of, the market study, the OFT received a number of complaints from patients regarding their inability to

find an anaesthetist who will charge within PMI provider fee schedules. These complaints have been supported by submissions and evidence from PMI providers as part of the market study that high concentration of AGs in some local markets may raise prices. In the light of these complaints, the OFT suspects that the prevalence of AG groups is also a feature of the market which may reduce price competition in local markets (particularly in view of switching costs such as the costs associated with postponing treatment or travelling to an alternative facility).

1.15 **Barriers to entry.** For the reasons analysed in chapter 8, the OFT considers that a number of features of the PH market combine to create significant barriers to entry. These are:

- Certain conditions imposed by larger PH providers as part of the recognition of their facilities on PMI networks which may restrict the ability of PMI providers to recognise new entrants attempting to offer competing PH services on their networks. For example, some PH providers impose conditions on PMI providers that they be consulted on the recognition of a new entrant on a PMI providers' network, or that impose price rises on a PMI provider should a new entrant be recognised.
- The practice of many consultants is to treat most of their private patients at one main PH facility. Since patients are insured by different PMI providers, this practice means that new entrants, attempting to offer competing PH services, need to be recognised on all of the main PMI networks in order to attract a sufficient number of consultants to practice at their facility (the 'consultant drag' effect).
- Incentives paid directly or indirectly by PH facilities to consultants to encourage them to treat all, or a higher number, of their patients at their facility. These incentives may further discourage consultants from treating patients at the facilities of new entrants, attempting to offer competing PH services.

In addition, in this context, the OFT notes the possibly emerging trend of the provision of financial incentives to GPs by PH providers in order to

encourage those GPs to refer patients to the PH provider's facilities. This trend may also have the potential to develop as a barrier to entry.

- 1.16 This combination of concerns around informational asymmetries, aspects of local concentration and wider barriers to entry, either individually or in combination, has the potential to prevent, restrict or distort competition in the PH market. The OFT considers that these significant underlying features of the PH market are more appropriately investigated further by way of a market investigation reference (MIR) and that the CC has recourse to the range of remedies which may prove appropriate to address the concerns identified by the OFT. Such remedies could include, for example, compelling the provision of certain information, the imposition of supply or pricing obligations on PH facilities, or potential bans on the imposition by PH providers with market power of certain types of contractual provision.
- 1.17 The OFT provisionally considers that the statutory test in section 131 of the Enterprise Act 2002 for making a reference is met and, taking into account the relevant criteria set out in the OFT's guidance document on MIRs, has provisionally concluded that the evidence points in favour of exercising the OFT's discretion to make a reference to the CC for the supply of PH.

Other market study findings

- 1.18 This report makes two recommendations to address particular issues that arose in the course of the market study. The OFT is pleased to be able to make these immediate recommendations following its engagement with participants and regulators in the PH market which it hopes will have some impact even before any definitive view is reached on an MIR.
- 1.19 First, responding to concerns expressed by consumers as to the level of extra payments sought from some consultants that are not covered under their PMI policies (shortfall payments), the OFT has since engaged with the FSA on this issue. Consequently, the FSA is in contact with the Association of British Insurers (ABI) and PMI providers to ensure that the PMI providers make clear the possibility of a shortfall payment as a result of the limits which apply to the amount payable under their policies. The aim will be to ensure that PMI providers make the risk of

shortfall payments clear to their customers both at the point of sale and at the time a patient makes a claim under a PMI policy. The OFT welcomes this development.

- 1.20 Second, the development of partnership arrangements between PPUs of NHS/Foundation Trusts and PH providers has the potential to either exacerbate or alleviate concentration in local PH markets. Local market concentration may increase if a PH provider that is already present in the local market partners with the PPU. This is because the partnering arrangement may remove any competitive constraint on the relevant PH provider offered prior to the partnering arrangement and reduce choice for PH patients and PMI providers. On the other hand, a partnership arrangement between a PPU and a new PH provider in the local market has the potential to provide a platform for entry and thereby to increase competition.
- 1.21 The OFT has therefore made a recommendation to the Department of Health and to the NHS/Foundation Trusts when seeking to agree partnership arrangements with PH providers to consider whether any arrangements between PPUs of Foundation/NHS trusts and PH providers may increase concentration in certain local markets with a consequent reduction in choice for patients, and a potential reduction in competition in those local markets. To this end, the OFT has also recommended that NHS/Foundation Trusts seeking to agree partnership arrangements with PH providers consider whether their arrangements are qualifying mergers and whether, as a result, to notify the arrangements to the OFT. This market study has also flagged to the OFT issues around whether Private Patient Units (PPUs) may be at a potential competitive advantage in PH markets due to any implicit, non-market benefits they could receive from their connections to NHS Trusts. Chapter 9 therefore considers how the principles of competitive neutrality might apply to publicly funded organisations competing in the PH market.

Consultation

- 1.22 The OFT is consulting on its proposed decision to make a market investigation reference to the CC.

1.23 The OFT invites comments by **30 January 2012**. Comments should be sent to:

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2 INTRODUCTION

- 2.1 The OFT aims to make markets work well for consumers. It achieves this by promoting and protecting consumer interests throughout the UK, while ensuring that businesses are fair and competitive.
- 2.2 The OFT is well placed, with its unique market study tool, to pursue valuable, holistic analyses of markets – both from a competition and consumer angle. Market studies are a non-intrusive and efficient instrument for diagnosis, cure or both. They can ensure that issues are not left unexamined. They can also be a means of applying informed technical skills to bespoke analyses of issues, such as whether barriers to competition are on the supply side or the demand side, whether they may be remediable and whether any potential remedies might have unintended consequences.
- 2.3 The OFT has embarked on this market study with considerable experience of considering issues across the PH sector, having considered several mergers across privately funded healthcare services and Private Medical Insurance (PMI) sectors and most recently having reviewed the merger of two PH providers in October 2010.² However, the last formal market review of the provision of PH was more than a decade ago, in 1999.³ The OFT also has a decade of experience of using and developing its market study tool.
- 2.4 This market study comes at a time of potential change in the wider landscape of healthcare provision in the UK, although no significant changes are anticipated to the PH market in the UK in the short-term. The OFT has engaged with a wide range of stakeholders throughout this market study and has focused, therefore, on setting out its findings in

² Since 2008 three mergers have been reviewed by the OFT in this sector, these are: (i) Completed acquisition by General Healthcare Group of control of four Abbey hospitals and de facto control over Transform Holdings Limited previously part of the Covenant Healthcare Group, October 2010, (ii) Completed acquisition by Spire Healthcare Limited of Classic Hospitals Group Limited, July 2008, and (iii) Completed acquisition by General Healthcare Group of assets of Nuffield Facilities, May 2008. The most recent being the Completed acquisition by General Healthcare Group of control of four Abbey hospitals and de facto control over Transform Holdings Limited previously part of the Covenant Healthcare Group, October 2010

³ www.of.gov.uk/shared_of/market-studies/40_99.pdf

this report with a view to assisting regulatory bodies with ongoing and new roles in regulating or reviewing healthcare markets, including Monitor as the economic regulator for health and the Competition Commission (CC) which, under current legislative proposals, is to review the development of competition in the provision of healthcare services for the purposes of the NHS every seven years.⁴

2.5 The OFT launched the PH market study in March 2011 following its own preliminary research, prompted by submissions made by a number of participants across the sector, which together called into question whether the market for PH is working well for consumers. This research pointed to a number of changes in the market for PH over the last decade, in particular consolidation amongst PH providers since the last OFT review in 1999, a move by PMI providers away from vertical integration and an evolving, and potentially more complex, interaction between the PH market and the NHS.

2.6 The PH market may also be increasingly important to the delivery of NHS services as a result of ongoing Government initiatives, such as the 'any willing provider' initiative, which are aimed at enabling NHS patients to obtain medical treatment from PH providers. The NHS is the second

⁴ Health and Social Care Bill, section 76

The Competition Commission must review—

(1) the development of competition in the provision of health care services for the purposes of the NHS, and

(2) the exercise by Monitor of its functions under this Part in relation to the provision of health care services for those purposes.

(3) Before beginning a review under this section, the Commission must publish a notice specifying the matters it proposes to consider in the review.

(4) In carrying out the review, the Commission must consider whether those matters have or may be expected to have any effects adverse to the public interest.

largest purchaser of PH and the proportion of NHS patients treated in PH has more than doubled in the last four years.⁵

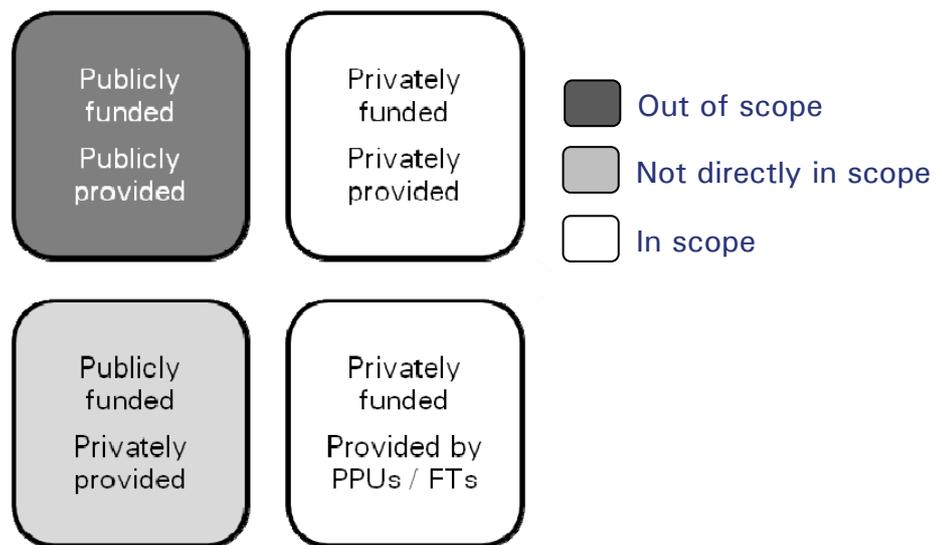
2.7 Submissions and meetings held with a range of market participants during the OFT's consultation on the proposed scope of the study confirmed that these issues merited further investigation.

Scope of the Market Study

2.8 The focus of the market study is on the provision of PH, which includes the provision of PH by privately funded public providers (for example, by Private Patient Units (PPUs) of NHS Trusts as well as private providers).

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

Figure 2.1 Focus on privately funded healthcare



2.10 The NHS's role as a purchaser of PH is also not directly within the scope of this market study due to various features which distinguish publicly funded healthcare from the PH market. In particular, pricing is set at the

⁵ Laing and Buisson, *Laing's Healthcare Market Review*, 2010-11, page 44.

level of the NHS tariff⁶ and the patient pathway and specification are set by the commissioning Primary Care Trust.^{7 8} By contrast, PH patients generally receive a number of additional perceived benefits such as greater choice of a consultant, the date of an outpatient appointment, and more immediate access to treatment. Pricing for PH, however, is negotiated separately with each purchaser, the large majority of whom are PMI providers acting on behalf of their customers (PMI funded patients) and this market study also examines this role.

- 2.11 The latest figures for PMI penetration show that approximately 15.8 per cent of the UK population are covered by a PMI policy. The market study focuses particularly on the PMI providers' relationships with PH providers, consultants and GPs.⁹

Overview of the PH Market

- 2.12 The market for PH encompasses a range of medical treatments which are privately funded and provided to patients via private hospitals/clinics and PPU's (referred to in this report as 'PH facilities'), through the services of consultants and medical and clinical professionals who work within these facilities.¹⁰
- 2.13 The OFT's consideration of PH has primarily focused on the provision of the acute¹¹ medical/surgical and diagnostic procedures provided in such

⁶ <http://data.gov.uk/dataset/payment-by-results-2010-11-national-tariff-information>

⁷ www.nhs.uk/NHSEngland/thenhs/about/Pages/authoritiesandtrusts.aspx#primary

⁸ Although not part of this market study, the NHS' role as a purchaser of PH was part of the Co-operation and Competition Panel's review of the 'Any Willing Provider' initiative, which reported in July 2011.

⁹ Private Healthcare – A Scoping Paper, OFT 1295, December 2010

¹⁰ Chapter 4 sets out an analysis of the product market and geographic market definitions in relation to PH services in the UK.

¹¹ For the purposes of this market study, acute care is defined as short-term treatment via a range of medical/surgical procedures commonly delivered by PH facilities within inpatient and outpatient settings. This excludes treatment for long-term conditions

PH facilities (including acute facilities with overnight beds and acute day surgery facilities/clinics) to privately funded patients (PH patients). However as set out in its Final Statement of Scope,¹² any findings and recommendations that the OFT makes will have a more general application across a wider range of PH services, and will not just be limited to those that are directly within scope.

- 2.14 In 2009, the total value of the market for acute PH in the UK was estimated at just over £4.94 billion. PH facilities account for the largest part of the overall PH market, generating an estimated £2.83 billion in revenue during 2009. Fees to surgeons, anaesthetists and physicians generated an estimated £1.64 billion in 2009.¹³ The remaining £0.47 billion is revenue generated by private inpatient and outpatient treatment in NHS facilities, for example in PPUs.

Evidence and Process

- 2.15 During the course of this market study, the OFT has received a large number of submissions from a range of interested parties active across the PH market, including: PH providers, PMI providers, consultants, other medical professionals, and professional bodies.¹⁴
- 2.16 The OFT has also commissioned and published four reports from independent consultants.
- The first report contains findings from a survey of 400 GPs (the OFT GP survey) and 400 consultants (the OFT consultant survey) via telephone and on-line interviews, to provide evidence and

¹² Private healthcare – final statement of scope, OFT 1295f, March 2011

¹³ Laing and Buisson, *Laing's Healthcare Market Review 2010-2011*, Table 1.2, page 35. Note the £4.94bn total market figure does not include revenue from the purchase of acute care by the NHS from independent facilities, revenue from mental health facilities or long-term care of the elderly.

¹⁴ Such as the British Medical Association, Federation of Independent Practitioner Organisation and the Association of Anaesthetists of Great Britain and Ireland, consumer organisations and individual consumers.

information on the relationship and interactions between GPs, consultants and patients.¹⁵

- Both these surveys were accompanied by a second report that sought to examine – mainly via a review of publicly available source information – the extent, nature and profile of the GP and consultant workforce in order to provide additional context for this market study (OFT population report).¹⁶
- The third report covers research which involved in-depth interviews with 40 patients who had recently received, or were currently seeking private treatment (the OFT patient interviews).¹⁷
- The final report, commissioned by the OFT and undertaken by the economic consultants Oxera, assesses the different techniques for defining markets for PH in the UK (OFT market definition report).¹⁸

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

2.18 In early September 2011, the OFT also held two roundtable discussions with 36 different organisations (including those active in the PH sector

¹⁵ GHK, *Programme of Research Exploring Issues of Private Healthcare Among General Practitioners and Medical Consultants – Final Survey Report*, August 2011, available at: www.of.gov.uk/shared_of/market-studies/Final-Survey-Report-08-2011.pdf

¹⁶ GHK, *Programme of Research Exploring Issues of Private Healthcare Among General Practitioners and Medical Consultants – Population Overview Report*, August 2011, available at: www.of.gov.uk/shared_of/market-studies/Population-Overview-Report-1.pdf

¹⁷ Opinion Leader, *The Patient Journey: Research to support the OFT's private healthcare market study*, August 2011, available at: www.of.gov.uk/shared_of/market-studies/The-Patient-Journey-Report.pdf

¹⁸ Oxera, *Techniques for defining markets for private healthcare in the UK*, 2011

and public bodies¹⁹) to consider its emerging findings regarding the provision of price and quality information by consultants and PH facilities, and to investigate further whether the OFT's concerns in this area could be addressed and, if so, within what time frame. A high level summary of these discussions can be found at Annex B.

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

2.20 The report is structured as follows:

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

¹⁹ Public bodies present at the roundtable discussions included: Department of Health, CQC, and the Council for Healthcare Regulatory Excellence (CHRE).

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

3 MARKET OVERVIEW AND THE PATIENT JOURNEY

Introduction

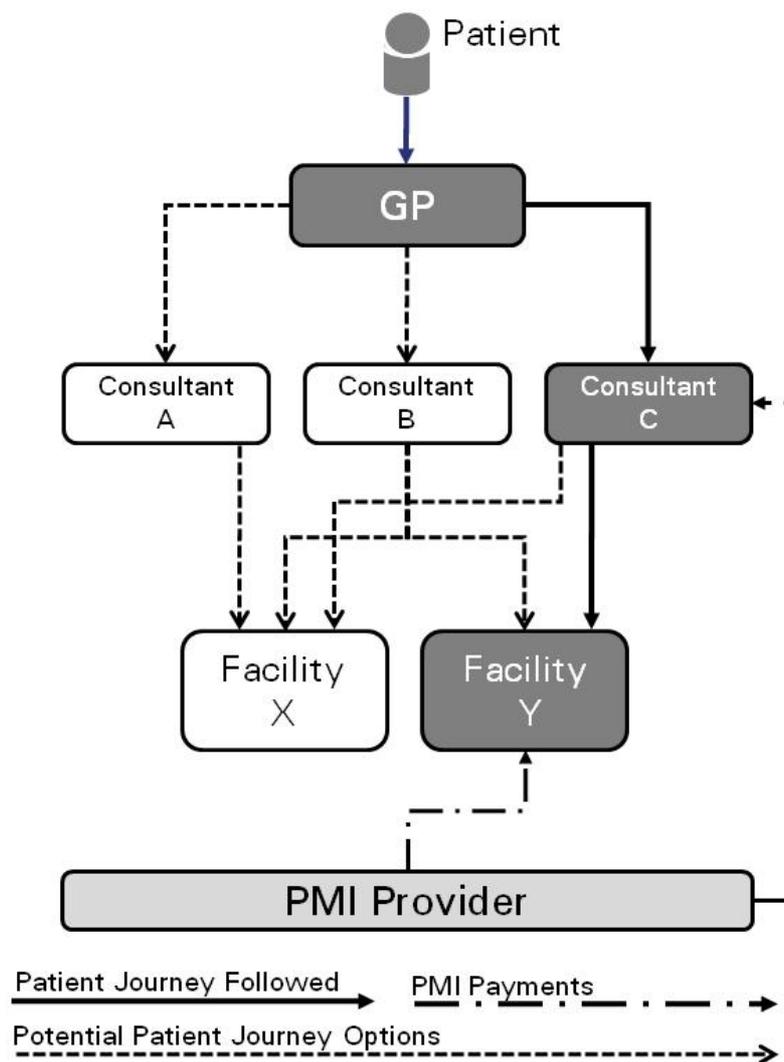
- 3.1 This section provides an overview of the PH market, exploring how the various market participants interact and the role of PMI in the context of PH. It also considers, where relevant, the role of privately funded public providers of PH, namely the NHS via the work of PPU's.
- 3.2 The PH market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

The Patient Journey

- 3.3 The route a PH patient takes from requiring treatment through to being treated in a PH facility is often termed the 'patient journey'. Figure 3.1 below shows the typical patient journey, which is based on submissions from stakeholders, the OFT patient interviews, the OFT GP survey and the OFT consultant survey.
- 3.4 GPs act as the key interface in directing PH patients to consultants and PH facilities, and in the provision of information to PH patients about their options of PH provider and consultant. Consultants also occupy a central position within the patient journey as GPs refer patients to consultants (rather than to PH facilities) in the majority of cases. The roles of GPs and consultants are also examined below.
- 3.5 The patient journey presented in this chapter represents the typical route via which most PH patients will access PH. However, the OFT notes, as seen in the OFT patient interviews, that alternative routes are also possible where a patient may place greater or lesser reliance on the different market participants identified.²⁰

²⁰ For more details on these alternative routes, please see: OFT patient interviews, pages 18-21

Figure 3.1 Typical Patient Journey for a PMI funded patient



PH Patients

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

interviews suggest that an important factor is the wish to be treated quickly, avoiding NHS waiting times.²¹

- 3.7 PMI funded patients typically have either a corporate policy, obtained through their employer, or an individual policy, obtained directly from a PMI provider. Publicly available figures suggest that 69 per cent of PMI sales in 2009 were to corporate customers.²²
- 3.8 Each PMI provider typically offers a series of different policies tailored to the needs of different customers. Each policy will list the PH facilities at which a policyholder is entitled to be treated. Most PMI funded patients are on a PMI network policy, the typical features of which are described in Box 8.1 in chapter 8.
- 3.9 If a patient does not have PMI cover, they can choose to fund their treatment themselves. This would involve ascertaining the cost of the treatment with a PH facility and paying both the hospital and the consultant fees (including the anaesthetist fee, if an anaesthetist is required) directly. In some instances, the PH facility may offer a 'package price' to the patient, this is an overall bundle price incorporating the hospital, consultant and anaesthetist fees. The proportion of PH patients that self-pay has fallen from approximately 18 per cent in 2004 to approximately 13 per cent in 2009. Laing and Buisson has indicated in its Healthcare Market Review 2010-11 that the proportion of patients who choose to self-pay is related to NHS waiting times – as NHS waiting times fall so does the number of patients who self-pay.²³

²¹ OFT patient interviews, at pages 21 and 24.

²² Laing and Buisson, *Laing's Healthcare Market Review 2010-2011*, Table 3.10, page 189.

²³ Laing and Buisson, *Laing's Healthcare Market Review 2010-2011*, page 44.

GPs

- 3.10 GPs act as the key interface between primary and secondary care.²⁴ In order for a patient to see a specialist consultant or unit at a facility (whether an NHS or a PH facility), a formal letter of referral from the patient's GP is normally required. Through this role of primary diagnosis and referral, GPs effectively act as the gateway by which patients access secondary care treatment.²⁵
- 3.11 Previous research relating to the provision of publicly funded healthcare by the Department of Health has repeatedly found that GPs also play a key role in the provision of information to patients about their options regarding healthcare facilities, both NHS and PH, and regarding consultants.²⁶
- 3.12 The OFT's research in this market study indicates that this finding is also relevant to the PH market. The OFT patient interviews and the OFT GP survey both indicate that patients place a great amount of trust in their GPs' opinions and recommendations.²⁷ GPs appear to be aware of this relationship of trust and their influence on patient choice. In the OFT GP survey, 74 per cent of GPs, when asked, thought that they were the

²⁴ 'Primary care' refers to services provided by GP practices, dental practices, community pharmacies and high street optometrists. 'Secondary care' is usually delivered in hospitals or clinics and patients are usually referred to secondary care by their primary care provider.

²⁵ See OFT patient interviews, where the report also identified other ways that patients can enter the PH market. For example, a patient may discuss private treatment while visiting an NHS hospital and enter the PH market this way or the patient may contact the consultant and/or facility directly to discuss treatment.

²⁶ For instance, in 2009 the Department of Health found that around half of NHS patients offered a choice of hospital relied on their GP as a source of information Department of Health (2009) Report on the National Patient Choice Survey – March 2009 p7. In total, GPs were mentioned by 49 per cent of the survey respondents compared to 33 per cent who used their own or family and friends past experiences, 7 per cent who mentioned a booklet about choice, and 6 per cent who used NHS Choices website.

²⁷ OFT patient interviews, page 22 and page 42.

most important influence on a patient's choice of facility and/or consultant.²⁸

Consultants

- 3.13 Consultants are specialist senior doctors²⁹ who typically base their work in hospitals and clinics.
- 3.14 Since 1997, any doctor taking up an NHS consultant position is required to be included on the Specialist Register as held and maintained by the General Medical Council (GMC).³⁰ The rules for entry onto the Specialist Register are set out in legislation,³¹ and include formal training in the relevant medical speciality leading to the award of a Certificate of Completion of Training (CCT) by a competent authority.³²
- 3.15 In general, consultants working in PH also hold an NHS consultant position. This is due to a combination of two factors:
- PH providers' admission criteria (which must be met by a consultant in order to gain practicing privileges at a PH facility) usually include being on the relevant GMC Specialist Register and holding a substantive NHS consultant position³³
 - PMI providers' recognition criteria (which must be met in order to treat patients funded by PMI) generally require that a consultant

²⁸ OFT GP survey, pages 26-27.

²⁹ This would include surgeons

³⁰ NHS consultants in position prior to 1997 may not be on the Specialist Register at present, although the GMC is looking into routes by which consultants in position prior to 1997 could be entered onto the Specialist Register.

³¹ As set out in The European Specialist Medical Qualifications Order 1995 (SO3208) following a European directive facilitating the free movement of doctors.

³² Currently the Postgraduate Medical Education and Training Board (PMETB) in the UK.

³³ As opposed to a honorary or temporary position

holds a CCT, is entered onto the GMC Specialist Register and is (or once was) in a substantive NHS consultant position.

- 3.16 As noted by the OFT population report ³⁴ – based on the most recent dataset available from 1992 – 84 per cent of consultants working in private practice also worked in the NHS, a further 15 per cent had worked in the NHS, and only one per cent of consultants in private practice had never worked in the NHS. Given both the PH providers' admission criteria and the PMI providers' recognition criteria, it is reasonable to estimate that a significant majority of consultants providing PH currently are also practicing NHS consultants.
- 3.17 Together with GPs, consultants appear to occupy a key position within the patient journey and have a significant role in the choices that patients make. This is evidenced by the manner in which PH patients tend to be referred to a consultant by their GP. Evidence submitted to the OFT indicates that around 85 per cent of GP referrals for PMI funded patients are to named consultants rather than 'open referrals' where the identity of the treating consultant is not specified.³⁵
- 3.18 The OFT consultant survey suggests that consultants also play a key role in the selection of the PH facility where a patient is admitted. For instance, the survey shows that only a small minority of consultants offered their patients a choice between their main PH facility and another PH facility.³⁶
- 3.19 Evidence submitted to the OFT suggests that even though consultants may hold admission privileges in a number of PH facilities, most tend to base the majority of their private work at one specific PH facility. For instance, the OFT consultant survey found that most consultants with

³⁴ OFT population report, page 6

³⁵ In making an open referral, a GP may specify the PH facility/specialist unit (by addressing the referral letter to 'Dear Colleague' for instance) or, in regard to some PMI funded patients, filling out a referral form that specifies neither the consultant nor PH facility. For more discussion of this latter type of open referrals under PMI managed care initiatives, see paragraphs 5.70 and 5.74.

³⁶ OFT consultant survey, pages 53-4 (3.4.2)

admission privileges at two or more PH facilities still reported that they would treat between 71 and 100 per cent of their patients in their main PH facility over an average month.³⁷ As discussed in chapter 8, evidence indicates that consultants want to treat patients at PH facilities that are recognised by all PMI providers as this gives them the widest possible pool of PH patient business at one PH facility. This is known as the 'consultant drag' effect.

PH providers

3.20 There are five main PH provider groups active in the UK, each of which owns a network of PH facilities located throughout the UK. These are: General Healthcare Group³⁸ (GHG), which operates a number of PH facilities through their subsidiary BMI,³⁹ Spire Healthcare⁴⁰ (Spire), Nuffield Health⁴¹ (Nuffield), HCA International⁴² (HCA) and Ramsay Healthcare UK⁴³ (Ramsay). These top five PH providers accounted for approximately 77 per cent of the PH market by revenue in 2010.⁴⁴ The market also includes smaller, independent PH facilities,⁴⁵ and NHS PPU's. We consider further below how PH providers interact with PMI providers and compete.

³⁷ OFT consultant survey, page 58

³⁸ www.generalhealthcare.co.uk

³⁹ www.bmihealthcare.co.uk

⁴⁰ www.spirehealthcare.com

⁴¹ www.nuffieldhealth.com/Individuals/Facilities

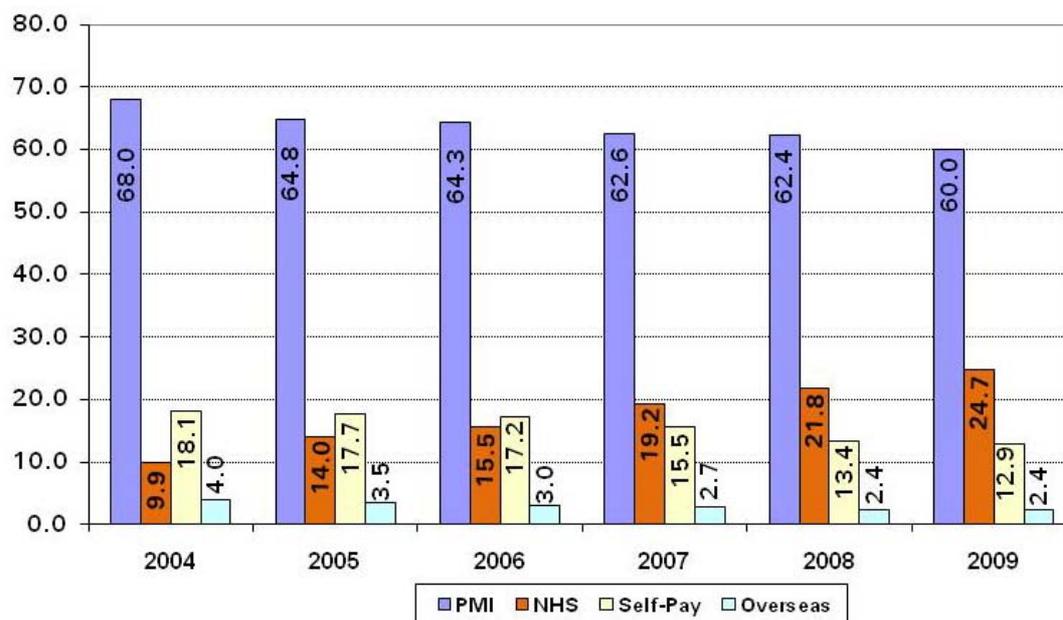
⁴² www.hcafacilities.co.uk

⁴³ www.ramsayhealth.co.uk

⁴⁴ Data supplied by Laing & Buisson from *Laing's Market Healthcare Review 2011-12*. The data excludes centrally procured ISTC activity and diagnostics for the NHS provided by specialist diagnostic providers.

⁴⁵ For instance, The London Clinic, The Horder Centre and The Hospital of St John & St Elizabeth.

Figure 3.2: PH funding sources, UK estimates 2004-2009



- 3.21 Publicly available sources⁴⁶ show that in 2009, PMI funded patients were the main source of revenue for PH providers, followed by NHS contracts, self-pay patients and overseas patients. These shares are illustrated by figure 3.2 above.
- 3.22 PH providers may have a range of PH facilities within their portfolio, from full service facilities,⁴⁷ to single line or specialist facilities, such as ophthalmology clinics or scanning facilities.
- 3.23 The larger PH providers all own a number of full service facilities which offer treatments across a wide range of specialities. Full service facilities will, therefore, typically have consultation rooms, theatres, in-patient beds and day-case beds and will offer in-patient, out-patient and day-case procedures.
- 3.24 Due to medical and technological advances over recent years, there has been a reduction in the volume of procedures conducted in an in-patient

⁴⁶ Laing and Buisson, Healthcare Market Review 2010-11, page 45, although this includes revenue from NHS funded patient who sought treatment from Independent Sector Treatment Centres (ISTCs see paragraph 3.28). Publicly funded patients treated in PH facilities are not within the scope of this study.

⁴⁷ Full service facilities are those that provide a wide range of treatments and procedures. This includes out-patient, in-patient and day-case procedures.

setting and an increase in the number of procedures that can be carried out within a day-case setting. Latest estimates from the Acute Market Monitoring Survey (AMMS), reported in Laing and Buisson, *Laing's Healthcare Market Review 2010-11*, show that 63 per cent of procedures are carried out in a day-case setting at full service facilities and this figure could be as high as 70 per cent if day-case only facilities⁴⁸ are included.⁴⁹

Interaction with the NHS

- 3.25 The NHS interacts with the PH market in various ways, as a provider of healthcare, a participant in the PH markets through a number of PPU, as a procurer of PH services and through any limits it may place on consultants to practice in the PH market.
- 3.26 The NHS is a provider of healthcare services free at the point of use and so may offer an overall constraint on the PH market, even though in terms of competitive interaction, in providing free healthcare, the NHS is unlikely to be in the same economic market as PH.⁵⁰ Nevertheless, NHS performance is an important determinant of the demand for acute PH, particularly for self-pay patients.⁵¹
- 3.27 The NHS is also a participant in the PH market, with just over 70 dedicated PPU and a number of private beds in NHS facilities.
- 3.28 Furthermore, the NHS is a procurer of PH services, as publicly funded patients seek treatments from PH facilities, such as Independent Sector

⁴⁸ These are facilities that only carry out day-case procedures, which are procedures that will require the patient to rest in a bed but do not require an overnight stay.

⁴⁹ See page 123.

⁵⁰ This is considered further at paragraph 4.30 in the next chapter.

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

Treatment Centres (ISTCs)⁵² and via a series of patient choice reforms⁵³ culminating in the 'Any Willing Provider' (AWP) initiative.⁵⁴

3.29 Finally, the NHS controls the availability of NHS employed consultants to the PH market. The OFT consultant survey showed that a consultant's NHS hospital may impose a constraint on the amount of PH work that the consultant could undertake in a given week or month. However, the OFT notes in this context that 27 per cent of consultants indicated that there were no such constraints on their PH practice and a further 28 per cent of consultants did not know whether there were any constraints on the amount of PH work they could undertake.⁵⁵

3.30 We discuss the role of, and interactions with, the NHS within the PH market further at chapter 4. In particular, we consider further the extent to which NHS facilities exercise a competitive constraint on the behaviour of other players in the PH market.

PMI providers

3.31 For PMI funded patients, the PMI provider will usually have an agreement in place with the PH provider to pay the cost of the treatment directly to

⁵² In 2002, the government chose to procure additional elective surgery capacity centrally from the independent sector through the ISTC programme, as part of an overall NHS strategy to improve the delivery of elective surgery by making large-scale reductions in waiting times. ISTCs are privately owned, but are free at point of use like other NHS facilities. Many ISTCs were new builds (sometimes on NHS facilities), although some were developed from existing NHS or PH facilities. Notable ISTC providers include Care UK and Ramsay Health Care UK.

⁵³ From the early 2000s onwards, NHS patients have been afforded greater choice over where to be treated. Major milestones within such reforms include: 2004, when NHS patients waiting for a range of elective surgery types were first offered a choice of hospitals by NHS managers, 2006, when patients were given the right to choose between at least four hospitals and then, in 2009, when patient choice of hospital became a legal right under the NHS Constitution. The OFT notes that many of these reforms only apply to the NHS in England rather than in Scotland, Wales and Northern Ireland.

⁵⁴As set out in the OFT's Private Healthcare Market Study Scoping Paper published in December 2010, NHS purchasing of PH is not directly within the scope of this market study.

⁵⁵ OFT consultant survey, pages 49-51

the PH provider. The PMI provider will also reimburse the consultant for their fees on behalf of the PMI funded patient.

- 3.32 The PMI provider may pay the consultant costs incurred in full or pay the costs up to a certain limit,⁵⁶ with the PMI funded patient sometimes paying shortfalls (when treatment costs unexpectedly exceed the PMI limit) or top-up fees (when an additional fee in excess of the limit is agreed between the patient and consultant before the treatment starts) directly to the consultant.
- 3.33 As discussed above, whilst it is typically the GP and the consultant that are key in determining where the patient is treated and by whom, in some instances the PMI provider also plays a role.⁵⁷ For example, albeit less frequently, the PMI provider may also help the patient choose a PH facility and/or consultant in the event that the GP provides the patient with an 'open referral' letter. This role is examined at paragraphs 5.62 to 5.67 below.
- 3.34 There are five main PMI providers active in the UK. These are Bupa,⁵⁸ AXA PPP,⁵⁹ Aviva,⁶⁰ PruHealth⁶¹ (which owns Standard Life Healthcare) and WPA.⁶² Together, these five PMI providers account for approximately 91 per cent of the revenue from PMI sales 'subscription income'.⁶³

⁵⁶ This is usually set out in a fee schedule operated by most PMI providers. Bupa's benefit maxima is often regarded as the industry standard. AXA PPP do not use a fee schedule, instead reimbursing to 'customary levels'.

⁵⁷ OFT patient interviews, page 22

⁵⁸ www.bupa.co.uk

⁵⁹ www.axapphealthcare.co.uk

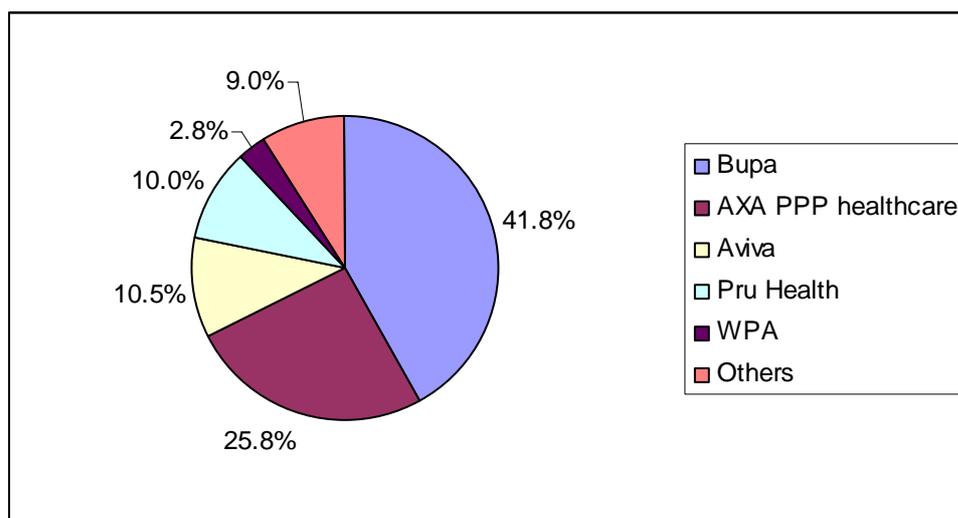
⁶⁰ www.aviva.co.uk/health-insurance

⁶¹ www.pruhealth.co.uk

⁶² www.wpa.org.uk

⁶³ *Laing's Healthcare Market Review 2010-11*, table 3.12, page 196

Figure 3.3: PMI shares of subscription income 2009⁶⁴

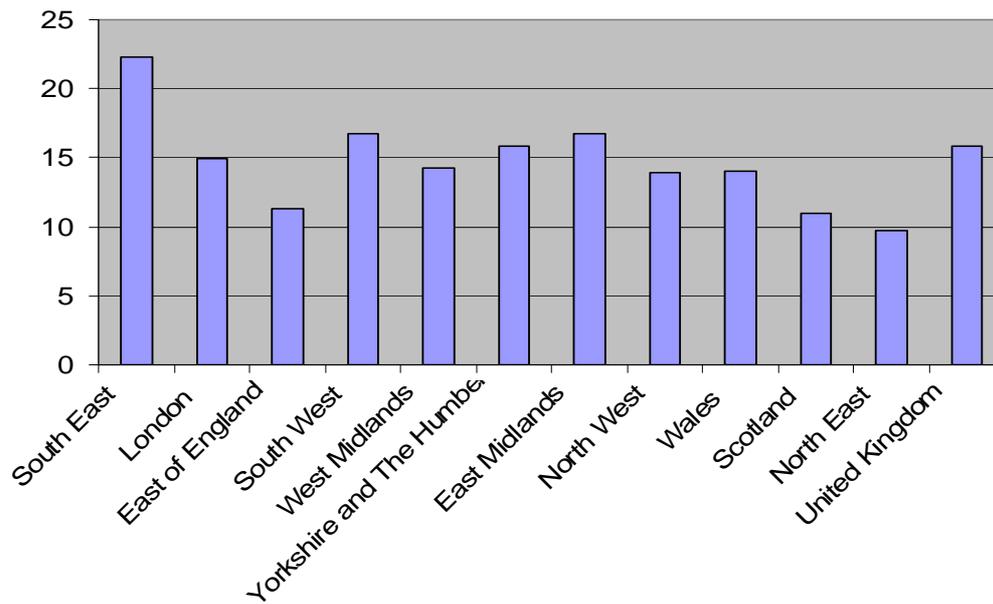


3.35 The subscription shares of the top five PMI providers have been relatively stable over the period from 2005 to 2009, with their combined shares increasing by six percentage points (from 85 per cent to 91 per cent). Over the period from 2006 to 2008, the number of PMI policyholders has also remained relatively stable, increasing by 35,000 policyholders (from 3,574,000 policyholders in 2006 to 3,608,000 in 2009).

3.36 PMI penetration varies by region, as figure 3.4 below shows. The South East of England has the highest PMI penetration with 22.3 per cent of the population in this region covered by PMI. The South West of England and the East Midlands both have a PMI penetration of 16.7 per cent. The North East of England and Scotland have the lowest PMI penetration, with 9.7 per cent and 11 per cent of the population covered by PMI and self-insured medical schemes respectively. Figure 3.4 below does not include PMI penetration for Northern Ireland as this figure was not presented in the data. The latest figures for Northern Ireland are present in Laing's Healthcare Market Review 2010-11 and shows that in 2006 PMI penetration was 7.5 per cent in Northern Ireland.

⁶⁴ Laing's Healthcare Market Review 2010-11, table 3.12, page 196 (figures shown on page 196 have been rounded up)

Figure 3.4: Geographic breakdown of PMI penetration 2010 ⁶⁵



⁶⁵ Proportion of Population Covered by PMI & self-insured medical expenses schemes (PMI Penetration) 2010 (%) Source: Target Group Index, Kantar Media, Quarter 2 (January 2010-December 2010); in Keynote, Private Healthcare, 2011

4 MARKET DEFINITION

Introduction

- 4.1 It is widely acknowledged that assessing the likely PH product and geographic market definitions is a difficult task. This is due to two main characteristics of the PH sector:
- heterogeneity of patients and PH facilities—patients' preferences, such as willingness to pay or willingness to travel to different PH facilities may differ between patients, while facility characteristics can differ by, for example, location or quality of service
 - lack of PH patient treatment price-sensitivity—the majority of patients fund their treatment through PMI, and are therefore insensitive to immediate increases in the price of treatment. Therefore, any market definition technique that relies on the patient's reaction to price is unlikely to capture the market accurately.⁶⁶
- 4.2 The OFT has not striven in this market study to arrive at conclusions on the definition of the relevant product and geographic markets concerned, as the OFT does not consider this to be necessary for an examination of the features as prescribed by the OFT's Market Investigation References guidance.⁶⁷

⁶⁶ Given some of the theoretical and methodological difficulties in defining markets for private healthcare, the OFT commissioned the economic consultants Oxera to undertake a literature review and assessment of the techniques for defining markets in private healthcare so that this may of use for future competition analysis. The findings of this report are reviewed in this chapter. Oxera, Techniques for defining markets for private healthcare in the UK, 2011

⁶⁷ *Market Investigation References – Guidance about the making of references under Part 4 of the Enterprise Act* (March 2006). 'In making a market investigation reference to the CC, the OFT must specify the goods or services for whose supply or acquisition competition is adversely affected. This will require some consideration of the definition of the relevant market.' The guidance provides further that '[t]he effects on competition of some feature may be clear enough that firm conclusions on the definition of the relevant market by the OFT are unnecessary'. See: www.of.gov.uk/shared_of/business_leaflets/enterprise_act/oft511.pdf

- 4.3 Rather, the OFT has sought to assess the relevant competitive constraints operating on the supply of PH that form the basis of likely product and geographic market definitions.
- 4.4 In line with previous OFT and CC merger decisions, the OFT considers the product market is likely to be the provision of privately funded healthcare services in the UK. These are provided to patients via private facilities/clinics including PPUs, through the services of consultants and medical professionals who work within these facilities.⁶⁸
- 4.5 In terms of extending the product market, the competitive constraint provided by PPUs varies based on the size of the PPU, the reputation of the NHS facility it is attached to, and the support it receives from local consultants. In some local markets, PPUs are likely to form part of the relevant product market.
- 4.6 The geographic market appears to be primarily national and local in nature. However, the OFT considers that there may be some regional aspects to competition, mainly for corporate PMI policyholders who are based in particular regions. For the purposes of this market study local markets have been defined using 30-minute drive time isochrones, centred on PH facilities.
- 4.7 As part of this market study, the OFT commissioned the economic consultants Oxera to produce a report assessing the different techniques for defining markets for PH in the UK (OFT market definition report).⁶⁹ While the OFT market definition report was commissioned as part of this market study, this report has wider value for the OFT, CC and other bodies in any future studies of this market and in any future merger

⁶⁸ Previous OFT and CC merger decisions: (i) Completed acquisition by General Healthcare Group of control of four Abbey hospitals and de facto control over Transform Holdings Limited previously part of the Covenant Healthcare Group, October 2010; (ii) Completed acquisition by Spire Healthcare Limited of Classic Hospitals Group Limited, July 2008; (iii) Completed acquisition by General Healthcare Group of assets of Nuffield Facilities, May 2008; and (iv) British United Provident Association Limited and Community Hospitals Group Plc: A report on the proposed merger; and British United Provident Association Limited, Salomon International LLC and Community Hospitals Group Plc; and Salomon International LLC and Community Hospitals Group Plc: A report on the existing mergers, December 2000.

⁶⁹ OFT market definition report

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

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

Product market

- 4.10 From a PH patient's perspective, whether they are self-paying or PMI funded, the product market is likely to be focused on particular treatments as, from the demand side, treatments or procedures are not usually substitutable. For example, a patient that requires a hip replacement could not substitute this procedure for a knee replacement. However, as noted in the OFT market definition report, for a particular treatment there may be several approaches that are to some extent substitutable, such as different types of hip replacement.⁷⁰ Treatments are also prescribed by a consultant and, as discussed in the next chapter, patients tend to place considerable trust in their consultant's recommendations.

⁷⁰ For example a hip replacement can be carried out with or without the use of cement.

- 4.11 In terms of supply side substitutes, consultation rooms and theatres can be used to perform a wide variety of procedures and treatments, provided that the consultants needed to perform these practice from the PH facility or that the PH facility could relatively quickly attract the necessary consultants. This also relies on the PH facility having, or being able to acquire relatively quickly, any specialist equipment needed, such as a MRI scanner. This is supported by the OFT market definition report, which states that the competitive constraint provided by one PH facility on another is likely to relate to a group of treatments rather than a single type of treatment.⁷¹
- 4.12 The OFT considers that the starting point for considering product market definition is, therefore, the provision of a wide range of treatments by a PH facility. It is however noted in the OFT market definition report that not all treatments will be capable of supply side substitution such that they will be part of a single product market range. Some PH facilities may be unable to quickly offer certain treatments that require particular consultants and equipment to perform them.
- 4.13 In terms of consultants, there is unlikely to be significant supply side substitution between consultants of different specialities due to the expertise and experience necessary to perform clinical procedures. For example an anaesthetist will not be a supply side substitute for a cardiothoracic surgeon.
- 4.14 As stated in chapter 3, consultants are required to be included on the Specialist Register as held and maintained by the General Medical Council (GMC). Entry onto the Specialist Register requires formal training in the relevant medical speciality, such as anaesthesia, ophthalmology and neurosurgery, leading to the award of a Certificate of Completion of Training (CCT) by a competent authority. It is considered that consultant specialities are therefore likely to be in separate product markets. It is however noted that for some treatments, the consultant product market may be narrower than the consultant speciality, where consultant sub-specialities may have developed to deal with those treatments. For certain other treatments, the consultant product market may be slightly wider than the consultant speciality where treatments may overlap

⁷¹ OFT market definition report

between two or more specialities. However, for the purposes of this market study, the OFT has not considered it necessary to examine this question further.

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

Previous definitions used by the OFT and CC

- 4.16 The report published by the CC on the proposed merger between Bupa and CHG in 2000⁷² considered the treatments that are typically covered by PMI to help define the product market for PH, whilst noting in the report that the relevant product market related to all PH patients, including self-pay patients. The report stated that 'acute facilities provide a wide spectrum of treatment services which accord closely with the range of treatments covered by PMI'.⁷³ The CC concluded that other PH facilities and clinics that are more specialised and typically deal with procedures that are not normally covered by PMI or offered by most PH acute facilities, such as cosmetic surgery and pregnancy termination clinics, are in separate product markets. This approach to product market definition has been applied by the OFT, in subsequent merger cases, such as the GHG/Nuffield merger in 2008.⁷⁴

⁷² British United Provident Association Limited and Community Hospitals Group Plc: A report on the proposed merger; and British United Provident Association Limited, Salomon International LLC and Community Hospitals Group Plc; and Salomon International LLC and Community Hospitals Group Plc: A report on the existing mergers, December 2000, available at: www.competition-commission.org.uk/rep_pub/reports/2000/449bupa.htm#summary

⁷³ See British United Provident Association Limited and Community Hospitals Group Plc: A report on the proposed merger; and British United Provident Association Limited, Salomon International LLC and Community Hospitals Group Plc; and Salomon International LLC and Community Hospitals Group Plc: A report on the existing mergers, December 2000, available at: www.competition-commission.org.uk/rep_pub/reports/2000/fulltext/449c4.pdf page 89

⁷⁴ Completed acquisition by General Healthcare Group of assets of Nuffield Facilities,

4.17 The CC and OFT have also noted in merger cases that PPUs⁷⁵ which provide a wide range of medical treatments and are available to PH patients on a full time basis should also be included in the relevant product market. The OFT noted that PPUs should be included in the relevant product market because they typically offered similar services to other PH facilities and were 'often included on the networks of PMI providers'.⁷⁶

Submissions made during this market study

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

4.19 In particular, PH providers maintain that PPUs do act as a competitive constraint on PH facilities and that this constraint is set to increase if the private patient cap⁷⁷ is removed.

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

May 2008, pg6. Available at: www.ofg.gov.uk/shared_ofg/mergers_ea02/2008/GHG.pdf. The report also noted that there is evidence that PPUs provide a weaker constraint on private facilities compared to other private facilities.

⁷⁵ There are 71 PPUs with 1,145 beds across the UK. Of the total 71 PPUs, 8 are managed by PH providers (also known as 'partnering'). This is discussed further in chapter 6.

⁷⁶ See Completed acquisition by General Healthcare Group of assets of Nuffield Facilities, May 2008, page 6. Available at: www.ofg.gov.uk/shared_ofg/mergers_ea02/2008/GHG.pdf

⁷⁷ The private patient cap applies to NHS foundation trusts, and it places a limit on the revenue these trusts can derive from private charges. The limit is set at the proportion of the total income that the trust derived from private charges in the base year, which is 2002-3. www.nhsconfed.org/Networks/FoundationTrust/Workstreams/Finance/Pages/PrivPatientIncomeCap.aspx

NHS Trusts appear to be imposing restrictions on NHS consultants, who also practice in the PH market, that limit the supply of consultants to PH providers in favour of their PPUs.

- 4.21 However, some PMI providers do not regard most PPUs as a competitive constraint on, or demand substitutes for, other PH providers in the market. A PMI provider commented that most PPUs tend to be very small (with few beds) and, therefore, do not provide a credible alternative in terms of scale to other PH facilities. Capacity is important to PMI providers because policyholders value PMI cover that enables them to be treated quickly, which may only be possible if there are beds available in local PH facilities.
- 4.22 One PMI provider that has launched a PMI policy based around patients being treated in PPUs in exchange for a lower premium has reported that this policy has a low uptake. Further, whilst the PMI providers state that their recognition criteria ⁷⁸ are generally the same for PPUs as for other PH providers ⁷⁹ it remains apparent that relatively fewer PPUs are recognised by PMI providers on their networks compared to other PH providers. PPUs themselves have reported that they have difficulty in securing PMI provider recognition. This is supported by evidence that PPUs are comparatively underrepresented on the major PMI providers' networks. ⁸⁰
- 4.23 The OFT notes that some PPUs do, however, seem to compete effectively with other PH providers and are considered by PMI providers to be viable alternatives. These PPUs tend to be based in London or other large metropolitan areas and attached to NHS facilities with strong established reputations and/or teaching hospital status. Eight of the top

⁷⁸ PMI providers have a set of criteria that PH providers must satisfy. The criteria relates to factors such as quality standards and price.

⁷⁹ Although one PMI provider states that it expects PPU prices to be at least 15 per cent cheaper than the prices of other private facilities in the same geographical area

⁸⁰ *Laing's Healthcare Market Review 2010-11*, page 82 shows that 27 out of 71 PPUs are not listed on either the Bupa or the AXA PPP standard hospital networks, and only 15 of the 71 are listed on both Bupa and AXA PPP standard hospital networks.

ten NHS trusts with the highest private patient revenue are based in central London.⁸¹

- 4.24 As discussed in chapter 3, consultants will often choose the PH facility at which they treat their patients. The OFT has, therefore, also considered consultants' views as to whether PPUs act as a competitive constraint on other PH providers. The OFT consultant survey found that just under half of the 400 consultants surveyed preferred to work from a privately owned PH facility rather than a PPU. Only 17 per cent of the consultants surveyed stated a preference for being based primarily in NHS facilities that treat PH patients.⁸²
- 4.25 The survey also found that a consultant's main PH facility is unlikely to be a PPU. Of those respondents that treated PH patients in one facility only, 78 per cent reported that this PH facility was not a PPU.⁸³ This does not preclude, however, that a consultant will also practice from a second PH facility which may be a PPU.
- 4.26 From a consultant's perspective, it would appear that PPUs provide only a limited competitive constraint on other PH providers. It may be the case that those PPUs that have support from local consultants may provide a greater competitive constraint on other PH providers.
- 4.27 The OFT also received submissions from a small number of PPUs during the course of the market study regarding how they compete with other PH providers in the PH market. PPUs point out that the first duty of care of the NHS facility to which the PPU is attached is to NHS patients, and that PPU beds may be given to NHS patients if needed. Further, some PPUs report that their NHS Trust often devotes very few resources (managerial and financial) to the PPU. However, the OFT notes that this

⁸¹ *Laing's Healthcare Market Review 2010-11*, page 80.

⁸² OFT consultant survey, pages 51-52, where most of the respondents did not have a preference.

⁸³ OFT consultant survey page 57-59. Of those who treated patients in two private facilities, only 11 per cent reported that their main facility was a PPU and 28 per cent indicated that their second facility was a PPU.

current situation may be subject to change if the private patient cap is removed.

- 4.28 The current pattern of competitive constraint provided by PPUs may also be affected by partnering arrangements between NHS Trusts and PH providers.⁸⁴ It is likely that the competitive constraint offered by some PPUs that have partnering arrangements with the larger PH providers will be increased as the PPU may benefit from the PH market expertise of the PH providers, such as the established relationships between the PH and PMI providers. The PPU may also benefit from the established, national, brands of the larger PH providers.⁸⁵
- 4.29 From the evidence gathered during the course of this market study, it seems that the degree of competitive constraint provided by individual PPUs varies. It appears that those PPUs that belong to NHS Trusts with the highest annual revenues from PH patients experience strong, and growing, demand – acting as a competitive constraint, therefore, on other PH providers - whilst other PPUs have generally experienced weaker demand.⁸⁶ The OFT believes that this differential is a result of the strong, established, international reputation of the NHS Trusts to which the PPUs are attached and the support from local consultants, which results in demand from self-pay and international PH patients as well as PMI funded patients.
- 4.30 Finally, some PH providers argued that the NHS as a whole, by providing a free substitute to PH, is a relevant competitive constraint. This view is inconsistent with the 2008 merger decision regarding the acquisition by General Healthcare Group of assets of Nuffield Facilities, which stated

⁸⁴ These partnering arrangements relate to PH providers having contracts in place to manage and operate the NHS PPU.

⁸⁵ However, PPU partnering may also have an impact on concentration in local markets. This is discussed in chapter 6 of this market study report.

⁸⁶ Laing & Buisson, *Laing's Healthcare Review 2010-11*, page 80, In 2008/2009, latest figures show that the NHS trusts with the highest annual revenues from treating private patients increased their combined private patient revenues by nearly 11per cent, compared with a marginal fall (down 1.3 per cent) in combined revenues for all other trusts.

that the willingness of customers to pay an extra charge for PH indicated that free services fell into a separate market.⁸⁷

Conclusion on product market

- 4.31 On the basis of the evidence submitted and a review of previous OFT and CC merger decisions, the OFT provisionally considers that the relevant product market is the provision of privately funded healthcare services in the UK. These are provided to patients via private facilities/clinics including PPU, through the services of consultants and other medical and clinical professionals who work within these facilities. It is likely that PPU that are attached to NHS trusts that have strong reputations and PPU that have support from local consultants provide a competitive constraint on other PH providers.
- 4.32 The OFT also considers that consultant specialities are likely to be in separate product markets.

Geographic market

- 4.33 The relevant geographic market is likely to be both national and local in scope. Competition takes place at the national level between the PH providers in their contractual relations with PMI providers. There are national negotiations between PH and PMI providers to agree national prices for treatments and procedures and to agree the PH provider's facilities that will be included on the PMI provider's networks. At the same time competition between individual PH providers takes place at a local level to attract consultants to their PH facilities, whilst PH patients also typically prefer to be treated close to home.

Previous definitions used by the OFT and CC

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

⁸⁷ Completed acquisition by General Healthcare Group of assets of Nuffield Facilities, May 2008, pg 5. Available at: www.offt.gov.uk/shared_offt/mergers_ea02/2008/GHG.pdf

'there are both local and national market influences' that are relevant to the appropriate geographic market definition.⁸⁸

- 4.35 In terms of the relevant local market definition, the OFT's approach in merger cases had been based on a 30 minute drive time analysis using isochrones centred on PH facilities.⁸⁹ The CC considered this to be appropriate, but stipulated that there were exceptions where the catchment area should be wider, such as in rural areas. The CC also considered that, for corporate PMI policyholders, there could be regional aspects as some PMI cover may be regionally based.
- 4.36 In the Spire/Classic merger analysis conducted by the OFT in 2008,⁹⁰ postcode analysis was also used in conjunction with 30 minute drive times.⁹¹ The OFT assessed the extent to which the parties' PH facilities overlap within 30 minute drive time isochrones. The parties also identified catchment areas that account for 80 per cent of the discharged patients from the parties' facilities. The OFT considered that both approaches can be useful indicators of the overlap in the catchment areas of PH facilities. However, both were noted to have limitations.⁹²
- 4.37 The OFT considers that the starting point for considering the relevant geographic markets is that there are both national and local geographic markets. There may also be some regional elements to competition. This differentiated geographic market definition is discussed further below.

⁸⁸ British United Provident Association Limited, Salomon International LLC and Community Facilities Group Plc; and Salomon International LLC and Community Facilities Group Plc: A report on the existing mergers, December 2000, pg 103, available at: www.competition-commission.org.uk/rep_pub/reports/2000/fulltext/449c4.pdf

⁸⁹ This was expected to capture around 80 per cent of the patients for that facility.

⁹⁰ Completed acquisition by Spire Healthcare Limited of Classic Hospitals Group Limited, 2008, available at: www.of.gov.uk/shared_of/mergers_ea02/2008/Spire.pdf

⁹¹ The analysis was provided by one of the parties.

⁹² The OFT market definition report also discusses the limitations of catchment area analysis.

Submissions made during this market study

National market

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

Regional market

- 4.41 The OFT has received divergent submissions across PH and PMI providers regarding whether there are regional elements to competition in the PH market or not.
- 4.42 A few PH providers have submitted that competition does not take place at the regional level. However, one smaller PH provider and a number of PMI providers have commented that regional elements to competition exist, and are significant. One PMI provider in particular has stated that some PH providers have a strong presence in particular regions and that, as some corporate PMI customers are regionally based, there are regional aspects to competition in relation to these customers.
- 4.43 The OFT has briefly, therefore assessed competition with regard to a possible regional geographic market definition where appropriate in this market study.

Local market

- 4.44 Competition takes place between different PH providers at a local level to attract patients to their facilities.
- 4.45 The OFT market definition report found that there were several techniques that have been used to define local PH markets. These range from long established techniques, such as isochrone analysis, critical loss analysis and the Elzinga-Hogarty test,⁹³ to more recent, advanced techniques based on merger simulation, such as competitor share and structural merger simulation approaches. The OFT market definition report can be found on the OFT website.⁹⁴
- 4.46 The OFT market definition report finds that the advanced techniques are conceptually more compelling, at least initially, compared to the earlier techniques. This is because, unlike the earlier techniques, the advanced techniques have been developed to account for the specific characteristics of the PH market, such as the heterogeneity of patients and PH facilities and the lack of sensitivity to prices of some patients (PMI funded patients especially). However, the OFT market definition report notes that these advanced techniques are only rarely likely to be viable and cost efficient for practical use by competition authorities in the UK because they require particular detailed patient level data that is often unavailable in the UK, and because the techniques are resource intensive.
- 4.47 The OFT market definition report notes that, if applying the more established, earlier techniques, an isochrone type measure is likely to be more appropriate than critical loss analysis or the use of the Elzinga-Hogarty test for defining PH markets. This is because both critical loss analysis and the Elzinga-Hogarty test rely on the assumption that PH patients are price sensitive, which is not an accurate assumption, especially for PMI funded patients.

⁹³ This test uses hospitals' patient flow data to gradually expand the geographic area around the focal hospital(s) until the inflows of patients from outside the area into local hospital(s) and the outflows of local patients to external hospitals both fall below an arbitrary 10–25 per cent threshold.

⁹⁴ Details regarding the different techniques for defining PH markets can be found in the report.

- 4.48 In past OFT merger cases, the OFT has defined local PH markets using 30 minute drive time isochrones. The OFT has considered, therefore, whether this previous geographic market definition at a local level adopted by the OFT in past merger cases continues to be appropriate.
- 4.49 The OFT market definition report found that isochrones based on drive times were more appropriate than fixed radius isochrones for defining local PH markets because fixed radius isochrones often lead to geographic markets being too widely defined in urban areas. Drive time isochrones take into account the local road networks and local speed limits and so the markets are less likely to be too widely defined in urban areas, which typically have lower speed limits.⁹⁵
- 4.50 The OFT has received divergent submissions in the market study from PH and PMI providers regarding whether the 30 minute drive time isochrone is appropriate to assess local levels of competition. Some PMI providers, for example, considered that an approach to local geographic market definition based on such isochrones may be appropriate for initial assessments but may not be appropriate for all locations. In rural areas, for example, the appropriate drive time within which to assess competition may be longer.⁹⁶ In addition, the availability and range of transport links may also impact on the appropriate geographical definition. For London, drive times alone may not be appropriate for defining local geographic markets due to the high use of public transport and the high volume of commuters.
- 4.51 It has also been suggested by a PH provider that the relevant local geographic market may actually be determined by consultants' working patterns. This may be because GPs tend to refer to consultants based on patient feedback and the GP's knowledge of local consultants. In this context, the appropriate geographic scope of competition may be determined in part by the consultant's willingness to travel to different PH facilities.

⁹⁵ OFT market definition report

⁹⁶ One PMI provider has noted that they believe local markets are better defined using narrower drive time isochrones, and a case by case approach has also been suggested by one PMI provider. This would involve assessing each locality individually to determine which facilities compete at a local level.

- 4.52 The relevance of the role of consultants in assessing the relevant geographic market definition is also supported by the OFT GP survey. The survey found that GPs believed that one of the most important factors that influenced patients when they made their choice of PH facility or consultant was the reputation of the consultant.⁹⁷ Also most consultants (96 per cent from the OFT consultant survey) undertake a mixture of private and NHS work and so there may be time efficiencies for the consultant in conducting their private work near their main NHS facility.
- 4.53 The OFT market definition report found that physician (consultant)-based isochrones have been used to define PH markets in a paper by Luft and Maerki.⁹⁸ The OFT notes that such a technique is not prevalent and has been challenged on the basis that even if consultants are only willing to travel a given distance to treat PH patients, the patients will have a choice of a number of consultant and facility pairings. However, as discussed above, GPs mainly refer patients to a named consultant and so the patient may be limited to the PH facilities to which the consultant they are referred to is willing to travel.
- 4.54 Taking these factors into account the OFT considers that the relevant geographic market is likely to be local, as well as national, in nature and it is appropriate for the purposes of this market study, given the timescale, the range of different local and national markets analysed in the market study and the data available, to assess local competition based on 30 minute drive time isochrones. Local markets are considered further in chapter 6 of this market study report.
- 4.55 In terms of consultants, the geographical market is also likely to be local. As discussed in the previous chapter, the majority of consultants undertake a mixture of NHS and private work and, therefore, consultants will typically have practicing privileges at a PH facility that is local to their NHS facility. This is supported by the OFT consultant survey, which

⁹⁷ OFT GP survey, page 28

⁹⁸ OFT market definition report

shows that 85 per cent of consultants who responded travel between zero and 30 minutes between their NHS and main PH facility.⁹⁹

Conclusion on geographic market

- 4.56 For the purposes of this market study, on the basis of the evidence submitted, the OFT market definition report and its review of previous OFT and CC merger decisions, the OFT considers that the relevant geographic markets are likely to be both national and local in nature, with potentially some regional aspects.

Conclusion on Market Definition

- 4.57 The OFT has not reached firm conclusions on the definition of the relevant product and geographic markets concerned, as the OFT does not consider this to be necessary for an examination of the features as prescribed by the OFT's MIR guidance. The guidance states that firm conclusions on market definition are unnecessary if the effect on competition of some feature(s) is clear enough.¹⁰⁰
- 4.58 In conclusion, the OFT provisionally considers that the relevant product market is likely to be the provision of privately funded healthcare services in the UK. These are provided to patients via private facilities/clinics including PPUs, through the services of consultants and medical and clinical professionals who work within these facilities.
- 4.59 The OFT considers that the geographical market is likely to be both national and local level. For the purposes of this market study, it is considered appropriate to assess local markets using 30 minute drive time isochrones. The OFT has also briefly considered regional markets where appropriate in this study as there are potentially some regional aspects to competition.

⁹⁹ OFT consultant survey, page 48

¹⁰⁰ *Market Investigation References – Guidance about the making of references under Part 4 of the Enterprise Act* (March 2006).

www.offt.gov.uk/shared_offt/business_leaflets/enterprise_act/oft511.pdf

5 INFORMATION ASYMMETRIES

Introduction

- 5.1 Accessible, standardised and comparable information is vital for ensuring that consumers can exercise informed choice so that markets work well. Information asymmetries, where suppliers have better information about the quality and price of a product than consumers, can dampen competition between suppliers and result in poor outcomes for consumers in terms of price, quality, innovation and productivity.
- 5.2 Certain information asymmetries are inevitable in healthcare markets given that patients are unlikely to know more about their condition than a medical professional, nor able to navigate their choices effectively without expert advice. Clinical procedures are typically experience or credence services and as a result quality is not directly observable by the patient. This means that experienced specialist judgments are often part of evaluating options and making choices between consultants and PH facilities. Most patients therefore place central importance on their GPs' advice concerning different consultants and PH facilities for this reason.
- 5.3 However, the OFT is concerned that there is a shortage of easily comparable information on the quality and price of different PH facilities and consultants available to GPs, patients and to PMI providers. This shortage may weaken the ability of these groups to drive efficiencies and to stimulate competition between different PH facilities and between consultants, and may give rise to a dampening of competition in the PH market overall.
- 5.4 This chapter examines the extent of information asymmetries in PH and their consequences in four main sections:
- the first section considers the importance of accessible, clear information for choice and competition in markets, and reviews how choices are made by patients in the PH market
 - the second section examines the current levels of information on the quality and prices of PH facilities and assesses the harm that may arise from an existing lack of standardised, comparable information

- the third section looks at the same issues in relation to a lack of information regarding consultants
- the fourth and final section addresses an important consequence of information asymmetries: the impact on the ability of PMI providers to inform their patients' choices and decisions in seeking better quality treatments and on the PMI providers' methods for constraining prices. This section considers how information asymmetries may result in PMI providers adopting what appear to be a number of blunt and potentially distortive policies in order to limit consultants' costs.

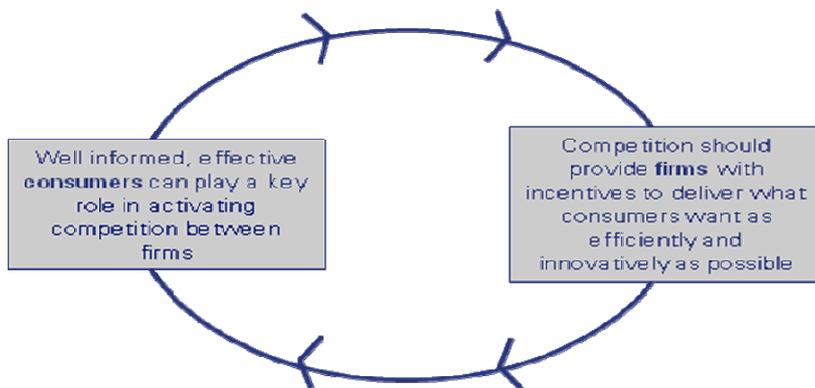
5.5 Additionally, chapter 6 examines how information asymmetries appear to limit the ability of PMI providers to exercise buyer power in the market.

Informed choice and competition

5.6 The OFT believes that well functioning, competitive markets are characterised by active and informed consumers. As set out in figure 5.1 below, active consumers exert pressure on firms to improve their product and service offerings. Informed consumer choice ensures that consumers are more likely to receive services that they need, and less likely to be inefficiently supplied services from which they do not benefit. This activates competition by rewarding those providers that deliver the best services that most suit their needs.¹⁰¹ Ultimately, empowered consumers and open competition drive innovation and productivity.

¹⁰¹ For further information setting out the OFT's views on this dynamic, please see: Office of Fair Trading, *Empowering consumers of public services through choice-tools*, April 2011 (OFT1321)

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



Source: The Office of Fair Trading

- 5.7 Well functioning markets do not require all consumers to be active and well informed. It is sufficient that some consumers exercise informed choice, or that others exercise informed choice independently on the consumers' behalf. It is key that those consumers that are willing and able to exercise well informed choices have the information to do so.
- 5.8 In relation to healthcare, patients clearly represent a widely diverse population and may differ in the degree to which they value choice and require different types of information on which to base choices. In addition, and in the context of PH, patients may follow different pathways in accessing treatment¹⁰² and self-pay patients are particularly likely to value choice in terms of price as well as quality. However, despite this diversity, recent research has indicated that patients in general value choice over their treatment.¹⁰³

¹⁰² OFT patient interviews, at pages 18-22, sets out the different pathways that patients may follow in accessing PH

¹⁰³ A recent report by the King's Fund has found that 75 per cent of patients surveyed thought that choice was either 'very important' or 'important'. (The King's Fund, *Patient Choice: How patients choose and how providers respond*, 2010, at executive summary (xiii)). Also, the 25th British Social Attitudes Survey (2009) reported that over 95 per cent of people think there should be at least some choice over which hospital a patient attends (as cited in OFT, *Choice and Competition in Public Services: Case Studies*, March 2010 OFT1214 at page 10)

- 5.9 In addition, GPs play a central role in how patient choices are made. The importance of the GP's role is confirmed by the OFT patient interviews which showed the large degree of trust and reliance that patients tended to place on their GP's opinion, with many patients seeking to delegate their choice of consultant to their GP.¹⁰⁴

Healthcare information asymmetries

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

¹⁰⁴ OFT patient interviews, at page 28, also illustrates how some patients may be less interested in directly exercising choice

- current information regarding the quality of care offered by consultants is largely absent, making a patient's choice over a consultant dependent upon the GP's recommendation which is based on informal information and which may, itself, dampen demand side competition
- the absence of information regarding the quality of care offered by consultants currently means that PMI funded patients cannot judge the value for money offered by agreeing to pay a 'top-up' fee¹⁰⁵ directly to the consultant. This is especially the case given that price may be used as a simple proxy for quality without any other supporting evidence¹⁰⁶
- potentially high search costs for self-pay patients in acquiring a breakdown of treatment costs at different PH facilities and a lack of the relevant information for judging value for money
- in a significant number of instances, consultants may not be providing PMI funded patients with fee estimates prior to providing treatment and this leads to a lack of consultant fee visibility for both the PMI funded patient and the PMI provider. This increases the likelihood of PMI funded patients facing an unanticipated payment of a consultant's fee (a shortfall¹⁰⁷) over the PMI provider's fee schedule¹⁰⁸ (or a 'customary level' normally reimbursed in full).

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

¹⁰⁵ For an explanation of a top up fee please see paragraph 3.32

¹⁰⁶ Based on submissions made by PMI providers.

¹⁰⁷ Please also see paragraph 3.32

¹⁰⁸ For a definition of fee schedule and how they operate, then please see paragraph 5.81

- a lack of information left patients confused and disabled them from making an informed decision.¹⁰⁹ They did not have sufficient information to compare consultants and/or PH facilities ¹¹⁰
- only a minority of GPs consider that 'all' or 'most' of their information needs regarding PH facilities were presently being met in regard to key PH facility performance variables, such as medical and clinical outcomes. Also, a significant number of GPs said that none of their information needs were met ¹¹¹
- only a minority of GPs consider that 'all' or 'most' of their information needs were presently being met in regard to key performance variables on consultants such as medical and clinical outcomes and prices. Again, a significant number of GPs also said that none of their information needs were met¹¹²
- only a minority of GPs felt that all their information needs were met in respect to the prices charged by PH facilities ¹¹³
- consultants have variable practices as to the provision of fee estimates to patients.¹¹⁴

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

¹⁰⁹ OFT patient interviews, page 47, paragraph 2

¹¹⁰ OFT patient interviews, page 47, paragraph 6

¹¹¹ OFT GP survey, pages 30-1

¹¹² OFT GP survey, pages 33-4

¹¹³ OFT GP survey, page 30

¹¹⁴ OFT consultant survey, pages 67-8

Current levels of information provision by PH facilities

Quality information provided by PH facilities

- 5.15 PH providers choose to advertise the quality of their facilities to a range of different audiences including consultants, GPs, PMI providers and patients. The two types of information on the quality of their offerings which tend to feature heavily in PH providers' marketing materials are:
- patient satisfaction surveys, and
 - clinical performance indicators.¹¹⁵
- 5.16 However, across this body of information, the OFT has identified considerable variations in how this information is presented which may hinder a patient's ability to compare different PH facilities. In particular, some key variations include: differences in the types of clinical indicators and patient survey questions used, differences in whether the data relates to a single PH facility or the PH provider's entire PH facility network, and differences in patient satisfaction ratings and the various methodologies for formulating these ratings.¹¹⁶
- 5.17 Such variability may affect the ability of patients¹¹⁷ to compare PH facilities and make an informed choice. The OFT understands that part of the reason for such variability in the format and display of comparable information on quality is the multiple systems used for recording private patient treatment episodes as managed by the different PH providers. Addressing this source of variability is the stated objective of the PH industry's Hellenic Project which is considered below.

¹¹⁵ For instance, infection rates or unplanned returns to theatre

¹¹⁶ For instance, one PH provider combines 'good', 'very good', and 'excellent' for an overall percentage figure on patient satisfaction, whereas another PH provider uses 'very good' and 'excellent'

¹¹⁷ The OFT patient interviews also indicates that some patients (termed 'self-led') were more involved in seeking out information about PH facilities and thus more likely to come into contact with issues surrounding the variability of currently published data as already described.

- 5.18 It has been reported extensively that similar difficulties in displaying clinical indicators also exist for NHS facilities.¹¹⁸ However, it appears that such difficulties are mitigated somewhat by the presence of the NHS Choices website¹¹⁹ which has sought to provide a standardised display of key quality indicators across all NHS facilities.
- 5.19 All publicly funded NHS patient episodes undertaken by PH providers must be submitted to the Hospital Episode Statistics (HES) database which, along with other databases, provide the basis for the information displayed on NHS Choices.¹²⁰
- 5.20 Whilst individual PH facilities may be listed on NHS Choices, the low volume of NHS funded episodes taking place in some PH facilities means that the data for certain key indicators is not sufficiently available in order to be displayed on the website.¹²¹
- 5.21 As NHS funded patient episodes represent only a subset of the work undertaken at most PH facilities, the low volume of HES records this produces (plus their lack of representativeness for the entire number of treatment episodes taking place at a PH facility) means that a third party comparative information provider on healthcare options, such as Dr

¹¹⁸ For examples of common difficulties in display of clinical indicators, see: The King's Fund, *How do quality accounts measure up? Findings from the first year, 2011*

¹¹⁹ www.nhs.uk/Pages/HomePage.aspx

¹²⁰ All NHS Facilities in England contribute to the HES database and, by virtue of their contracts with the NHS, so will PH providers. Each HES record represents a single episode of care and can contain more than 50 pieces of information ranging from information about the patient (age, gender), clinical diagnosis and treatments, and administrative data such as dates of admission, discharge and, since 1998, a consultant code identifying the treating / supervising consultant. The HES database provides the basis for several information fields on the NHS Choices website such as: unplanned readmissions to hospital, adjusted mortality ratios, and volume data on number of operations/type undertaken.

¹²¹ These fields often show the words 'insufficient data' or 'not held for...' and are attributable to low volumes of NHS funded patients.

Foster, has been unable to provide comparable report cards¹²² for PH facilities akin to those produced for NHS facilities.¹²³

- 5.22 Overall, whilst PH facilities treating NHS patients will contribute to the HES database, this does not result in a comprehensive, clear means by which PH facilities can be readily compared to each other or to NHS facilities in a standardised format.¹²⁴

The Hellenic Project

- 5.23 The Hellenic Project is a PH provider-led initiative to develop a uniform system to record all privately funded treatment episodes in a manner which mirrors the HES database used by the NHS. Aside from its stated aim to improve benchmarking and quality improvement, during the course of this market study the OFT has been informed that a further ambition of the project is to provide, via outward facing output, more comparable information on the quality of PH facilities for the benefit of patients.
- 5.24 The project started in 2009 and involves the main five PH providers. The OFT has been informed that a central challenge for the project has been collating the output from the various individual IT systems and databases of the different PH providers into a standardised format, and the OFT recognises that any such project will require an investment of time and resources.
- 5.25 The OFT welcomes this initiative and the aim of the project to provide access to more standardised, comparable information on PH facilities for patients. However, the OFT has two remaining broad concerns. These are:

¹²² As seen at: www.drfoosterhealth.co.uk/quality-reports Dr Foster produces report cards for every NHS hospital based on a traffic light system display and risk adjusted indicators measuring performance across a number of clinical activities

¹²³ Recently, Dr Foster has been able to produce comparable measures for some procedures (notably knee and hip replacements) undertaken at PH facilities in respect to NHS patient episodes only, and not for PH patient episodes.

¹²⁴ For further details on this issue, see annex B

- **Comparison with NHS:** As outlined in greater detail at annex B which sets out a high level summary of the OFT roundtables on these issues, a number of participants expressed concerns as to whether the output of the Hellenic Project, if successful, will allow effective comparison with NHS facilities for the benefit of all patients (regardless of funding source). Some participants also questioned whether the degree of comparability envisaged by the Hellenic Project's output was sufficient – especially when compared to what can be achieved via the current HES database.
 - At the OFT roundtables, some participants were keen to emphasise that the distinction between a 'NHS patient' and a 'private patient' was an increasingly academic one with patients often switching between public and private providers. As a result, some participants believed that any changes which maintained this distinction, or risked frustrating the ability of patients to compare facilities between sectors, would not be sufficient in addressing present information asymmetries. However, the discussions at the OFT roundtables saw a degree of resistance from some participants who considered that the owners of the data may wish to retain control of the data relating to PH patient episodes and did not favour its inclusion on the NHS Choices website.
- **Need for mandated PH involvement and a committed deadline:** In order to ensure effective comparison between PH facilities, the project will need to deliver accessible, standardised and comparable data for all PH facilities. To achieve this, it may well be that some PH providers will need to be mandated to participate fully in the project and make the requisite investments in IT systems necessary for the realisation of the Hellenic Project's objectives.
 - A number of participants at the OFT roundtable meetings have individually contacted the OFT to express doubts as to the ability of PH providers to reach consensus on a final output. They have also remarked that there had been no indication from PH providers until their commitment expressed at the OFT roundtable meeting, that the Hellenic project would produce an output which would allow comparability by facility. As a result

they consider such an output should be mandated. This would also prevent poorer performing PH facilities from opting out.

Price information for PH facilities

- 5.26 For PMI funded patients, the cost of a PH facility's inpatient charges will be covered by the PMI provider provided that facility is listed on the PMI providers' network (see chapter 8). During the course of the OFT's market study, the OFT received no evidence detailing situations where a PMI funded patient had unexpectedly been required to bear the cost of the PH facility's inpatient hospital charges by its PMI provider. A PMI funded patient is therefore unlikely to be price sensitive in his/her choice of PH facility.
- 5.27 By contrast, self-pay patients are likely to be more price sensitive and they could in principle play a role in driving price competition between PH facilities.
- 5.28 For self-pay patients, the evidence received in this market study suggests that information relating to the pricing of different treatments at a PH facility tends to be upfront and transparent,¹²⁵ and that many PH providers offer 'package prices' for various treatments where the consultant's fee is combined with the PH facility's entire hospital charges.
- 5.29 However, the OFT does have some concerns about the ability of self-pay patients to compare one quoted PH facility price for a treatment with another PH facility price in order to evaluate whether a quoted price represents value for money. In particular, search costs incurred by self-pay patients in obtaining individual quotes for treatment may be increased given that:
- there is some variation as to what may be included in a package price and this may vary by treatment and by PH facility
 - unless they have a private GP, self-pay patients may not be able to rely on their GPs for advice concerning the cost of specific clinical

¹²⁵ OFT patient interviews, at page 38

procedures at a particular facility as this information is not likely to be known by the GP ¹²⁶

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

¹²⁷

Specific harm arising out of PH facility information asymmetries

5.30 The ability of a patient to make an informed choice between PH facilities (as opposed to consultants – see below) appears to be impaired by a lack of accessible, standardised and comparable information on the quality of PH facilities. This makes it difficult for patients to evaluate – either independently or with the assistance of their GP or PMI provider – any choice they may have in relation to different PH facilities other than on the basis of geographical location and/or waiting times.¹²⁸

5.31 Whilst the location of a PH facility currently appears to be an important factor bearing upon a patient's choice, there is evidence to suggest that patients may rate other factors such as the quality of care or infection rates more highly and would therefore be willing to travel further afield if such accessible, standardised and comparable information were available.¹²⁹

¹²⁶ As with other information types, only a minority of GPs in the OFT GP survey felt that all their information needs were met in respect to prices (page 31).

¹²⁷ OFT patient interviews, at page 39

¹²⁸ OFT patient interviews, page 48, conclusions 6 and 9

¹²⁹ For instance, within the context of a hypothetical choice experiment, the King's Fund found that 45 per cent of patients surveyed would choose a non-local provider on the basis of differences between hospital characteristics. (See King's Fund, *Patient Choice: How patients choose and how providers respond*, 2010, at page 152). Furthermore, the National Patient Choice Survey found that the location of the hospital ranked below cleanliness/low levels of infection and quality of care in factors considered important for patients when choosing a hospital [in total location came sixth out of the ten factors identified] (See Department of Health, *Report on the National Patient Choice Survey*, March 2009, at page 8)

- 5.32 Whilst GPs consider that individual information sources for PH facilities are useful, ¹³⁰ significant numbers of GPs do not consider that the majority, or even any, of their information needs were presently being met as to key PH facility performance indicators across a range of factors, such as medical and clinical outcomes.¹³¹
- 5.33 At the present moment, the PH market compares unfavourably with the NHS in terms of the ability for patients to compare the quality of different facilities.¹³² Whilst not discounting the significant challenges involved in developing and providing access to such, standardised comparable quality information, the OFT considers that more opportunity should be afforded to patients (regardless of funding type) to compare PH facilities across both sectors in order to enhance their ability to make informed choices regarding treatment.
- 5.34 As set out in paragraph 5.29 above, it is also possible that self-pay patients may be at a disadvantage in being able to evaluate whether a price for a particular PH treatment represents value for money. This may be especially the case given that self-pay patients do not tend to negotiate the prices of their medical treatment and tend to accept the price quoted to them.¹³³
- 5.35 The OFT considers that the current absence of access to, standardised, comparable information on the quality and self-pay prices of PH facilities, weakens the ability of patients, GPs and PMI providers to drive efficiencies and stimulate competition between rival PH facilities and this may give rise to a dampening of competition between PH providers. Within a healthcare landscape increasingly characterised by patients choosing between private and public providers, this lack of standardised comparable, information is likely to perpetuate information asymmetries.

¹³⁰ OFT GP survey, page 30, (figure 2.30)

¹³¹ Such as medical and clinical outcomes, prices and waiting times (OFT GP survey, page 30)

¹³² See above at paragraphs 5.18 and 5.19.

¹³³ OFT consultant survey, at page 68, found that 43 per cent of consultants reported that their self-pay patients 'never' attempted to negotiate the level of their fees.

Current levels of information provision by consultants

Quality information for consultants

- 5.36 There appears to be a shortage of accessible, standardised, comparable information relating to the clinical performance of consultants for the benefit of patients, GPs and PMI providers.
- 5.37 Currently, the information on consultants offering PH accessible to patients is largely restricted to a directory of consultant names, their specialities and the locations where these consultants may practice.¹³⁴ Standardised, comparable information relating to a consultant's clinical performance is not generally available either to patients, GPs¹³⁵ or PMI providers,¹³⁶ and neither is such information available for consultants also working in the NHS.¹³⁷ Additionally, in relation to information on the locations where consultants practice, the OFT's consultant survey indicated that consultants themselves tend not to give their patients a choice between PH facilities for treatment.¹³⁸

¹³⁴ OFT patient interviews, at page 47, conclusion 2

¹³⁵ As shown in: *The King's Fund: An Anatomy of GP Referrals, 2007*, where GPs were described as having: 'a sort of 'mental' filing cabinet of informal information or soft intelligence about local consultants.' (page 20), see pages 19-22 in particular

¹³⁶ OFT consultant survey, at page 50 (3.3.4), shows that just 14 per cent of consultants share information about clinical outcomes or complications arising from their private practice with PMI providers.

¹³⁷ The OFT notes that, as recently outlined in *Liberating the NHS: Greater Choice and Control* Government response: Choice of named consultant-led team (Department of Health Oct 2011), the NHS is set to allow patients the ability to choose a consultant-led team from April 2012 where clinically appropriate. DH's consultation on this proposal found that there was a need for good quality information to support choice, and NHS providers will have to publish greater information about such consultant-led teams (such as their clinical specialities). See: www.dh.gov.uk/prod_consum_dh/groups/dh_digitalassets/documents/digitalasset/dh_131005.pdf

¹³⁸ OFT consultant survey, at page 53, shows that under half of consultants (48 per cent) said that they never offered patients a choice between their main PH facility and another PH facility.

- 5.38 The OFT is aware that certain surgical specialities have been making headway in relation to the provision of data which can provide a basis for comparison between consultants' clinical performance. A key example of this, as presently available to patients, is in cardiothoracic surgery where risk adjusted survival rates for each surgeon are made available to patients on the CQC's Heart Surgery website.¹³⁹
- 5.39 The OFT considers that there would be considerable benefit in extending similar types of standardised performance measures to other clinical specialities where possible in order to address information asymmetries.
- 5.40 The OFT acknowledges the views of some medical associations which have outlined significant methodological difficulties in defining meaningful and objective clinical performance measures for some specialities, whilst also warning how such measures may create perverse incentives.¹⁴⁰ However, the OFT understands that other medical associations appear to be more amenable in developing such information.
¹⁴¹
- 5.41 The OFT considers that even limited clinical performance information such as basic volume data on the number and type of procedures undertaken are likely to be beneficial for patients seeking to choose between consultants.
- 5.42 The OFT considers that while a short term investment may be necessary to establish robust indicators of clinical performance, such an investment is very likely to be rewarded by significant improvements in choice, competition and standards over the longer term. This is because performance information helps to inform patient choice, which drives competition between consultants. It also provides a benchmark by which

¹³⁹ This is a product of the Society for Cardiothoracic Surgery in Great Britain and Ireland's development and collection of benchmarked outcome data

¹⁴⁰ As discussed at the OFT roundtables (see annex B)

¹⁴¹ For instance, bariatric surgery in regard to the development of the National Bariatric Surgery Registry (NBSR).

consultants can gauge their own performance, This can ultimately raise performance standards across the market.¹⁴²

Consultant fee visibility

- 5.43 Most PMI providers publish fee schedules which establish the maximum level at which they will reimburse the consultant for a specific procedure. If a consultant's fee is unexpectedly over that fee schedule, it is the patient who is liable for this shortfall and this may be paid directly to the consultant by the patient.
- 5.44 PMI funded patients tend not to be price sensitive.¹⁴³ The effect of PMI cover appears to be to rule out any discussion of the consultant's fee for the procedure despite the fact that the PMI funded patient is made liable for any shortfall which may arise.¹⁴⁴
- 5.45 Although professional guidance to consultants working in private practice – in addition to the CQC standards¹⁴⁵ applying to the PH facilities they operate in – emphasises the need for upfront transparency on the issue of fees wherever possible,¹⁴⁶ the use of fee estimates by consultants and the timing for when these estimates may be given to a patient varies greatly between consultants. For instance, the OFT

¹⁴² See: The Society for Cardiothoracic Surgery in Great Britain & Ireland, *Maintaining patients' trust: modern medical professionalism* (2011), where a new model focusing on robust data on clinical outcomes is identified as the reason for a 50 per cent reduction in risk adjusted mortality in the UK (page 13)

¹⁴³ See paragraph 4.1

¹⁴⁴ OFT patient interviews, at page 48, conclusion 8

¹⁴⁵ CQC is a regulator of quality and safety under the Health and Social Care Act 2008, it has confirmed that Regulation 19 of the CQC Regulations relating to fees provides for a 'statement' which must be in writing and as far as possible, is made available before the services are provided. However, CQC cannot mandate that the information is always provided before the service is received, although it suggests it should only be exceptional where it is not.

¹⁴⁶ For instance, see point 11 of FIPO's Patient Information Leaflet available at: www.fipo.org/resources/rar-leaf.pdf and GMC Good Medical Practice Guide available at: www.gmc-uk.org/static/documents/content/GMP_0910.pdf

consultant survey found that less than half of consultants provided a fee estimate at the first consultation.¹⁴⁷

5.46 Some PMI funded patients may not be aware of the possibility of incurring a shortfall, assuming that the total fee will automatically be covered by their PMI provider. Others may not seek to pre-authorise their treatment, or even if they do, may not be in possession of an estimate of the consultant's fee (and the CCSD code¹⁴⁸ for the procedure) in order to check with the PMI provider prior to the procedure whether the entire cost will be covered. The OFT has raised this issue with the FSA and has made a recommendation to PMI providers in this regard.¹⁴⁹

5.47 Levels of shortfailing can differ sharply across different clinical specialities and between different procedures. Evidence submitted to the OFT in the market study suggests that anaesthetics constitutes a clinical speciality with a high rate of shortfailing as compared to other specialities.¹⁵⁰ This may be due to patients having limited opportunities to choose between different anaesthetists. PH patients' contact with anaesthetists can often be limited and sometimes restricted to a brief meeting on the day of the treatment.¹⁵¹ The ability of patients to

¹⁴⁷ OFT Consultant Survey, at page 128, details a breakdown of: 'at the first consultation (43 per cent), 'once expected treatment process is agreed' (28 per cent), 'at a later stage' (six per cent), 'when treatment is complete' (one per cent), 'do not provide estimates before the final fee' (13 per cent). See also FIPO's own survey of its members (available at: www.fipo.org/docs/axa-ppp/survey-detail-may-2010.htm) where 30.7 per cent of consultants did not give fee estimates.

¹⁴⁸ The Clinical Classification and Schedule Development Group (CCSD) - a group of representatives from the five main PMI providers - maintains a schedule of treatment codes covering clinical procedures undertaken in PH. Further information can be found at: www.ccsd.org.uk/Home

¹⁴⁹ See Chapter 9. The FSA is in contact with the ABI and PMI providers so that the incidence of shortfalls will be made clearer to consumers in their policy literature and also at time when a consumer seeks authorisation to make a claim under his/her policy.

¹⁵⁰ Based on submissions from a number of PMI providers.

¹⁵¹ We note that out of the (albeit small) number of patients interviewed; only two patients raised the subject of their anaesthetist in the OFT patient interviews, at page 32. It is also the

negotiate lower fees may be reduced through the concentration of anaesthetists as member of anaesthetist groups in certain local markets. This is considered further in chapter 7.

- 5.48 Finally, in relation to fees for a first consultation charged by consultants, the OFT GP survey found that most GPs rarely or never knew a consultant's first consultation fee and, when prompted, a number of GPs requested better information in regard to these fees.¹⁵² The OFT notes that some consultants do publish their fees for first consultations online, although – like the giving of fee estimates – this practice also seems variable.

Specific harm arising out of consultant information asymmetries

- 5.49 In general, the OFT's research suggests that PH patients, GPs and PMI providers would value greater information on the clinical performance and quality of care offered by consultants.
- 5.50 For patients, a great deal of reliance is placed on GPs as a result of a lack of access to standardised and comparable information,¹⁵³ and that patients, therefore, tend to choose a consultant who is suggested by their GP.¹⁵⁴
- 5.51 GPs tend to refer patients to named consultants rather than providing an 'open referral' to a PH facility.¹⁵⁵ The main factor GPs tend to consider when making a referral is the consultant's reputation.¹⁵⁶

case that a surgeon, at the time of booking the procedure, may not know the identity of the specific consultant. For instance, see FIPO's template consultant booking letter (available at: www.fipo.org/resources/index.htm) which allows room for this possibility via its wording

¹⁵² OFT GP survey, pages 34-5

¹⁵³ The OFT patient interviews, page 47, conclusions 2, 6 and 9. See also, Theme 6 (pages 41-46)

¹⁵⁴ OFT GP survey, at pages 24-25

¹⁵⁵ Evidence submitted to the OFT by PMI providers typically identified around nine out of ten GP referrals being made to named consultants rather than an 'open' referral

- 5.52 For GPs, as was the case with information for PH facilities, individual sources of information for consultants tended to provide only 'some' useful (as opposed to 'significant' amounts of information), and most GPs indicated that only 'some' or even 'none' of their information needs were presently being met as regards key consultant performance measures.¹⁵⁷
- 5.53 GPs use their knowledge from relationships with specific consultants, feedback from patients, information from marketing materials provided by PH facilities and informal social contacts with health professionals to help them advise patients as to treatment options.¹⁵⁸ Given the lack of access to standardised, comparable information on the clinical performance of consultants, information obtained via word of mouth and past patient experience¹⁵⁹ may be particularly influential and relied upon by GPs when recommending a consultant.¹⁶⁰
- 5.54 Although this 'soft' intelligence may provide information to aid choices locally and is to be valued, it will not assist patients who, if provided with relevant information, may want to be treated by consultants other than those with whom the GP is familiar. These factors may be especially the case where a GP (such as a locum) has little connection

¹⁵⁶ OFT GP survey, at page 22

¹⁵⁷ OFT GP survey, page 35

¹⁵⁸ This dynamic is found in *The King's Fund: An Anatomy of GP Referrals, 2007*, and can also be detected via consultants' own preference for informal networking with doctors when seeking to build their private practice (OFT consultant survey, pages 45-6)

¹⁵⁹ OFT patient interviews, at page 27, where a patient had reported that: '...the preferred consultant (from a list of three) was someone the GP had referred a lot of patients to and who had received positive feedback from them.'

¹⁶⁰ OFT GP survey, at pages 32 and 55-6, shows that 72 per cent of GPs used informal social contacts with health professionals as a source of information about privately practising consultants (the second most common source after information sent by PH facilities), and that the most common method for consultants to increase their private work was via informal networking with doctors (66 per cent), whilst over a quarter also mentioned visiting/contacting GPs.

with the local area and is therefore not privy to the types of soft, local information typically utilised.

- 5.55 Over-reliance on soft intelligence or informal views can also raise the risk of entrenched referral patterns or biases which dampen demand-side competition in PH. It may also inhibit efforts by the GP to explain to the patient the basis for their recommendation of a particular consultant or to elaborate to a patient a meaningful choice of consultants.¹⁶¹ Such a reliance on soft intelligence may also not result in a comprehensive information platform for the making of a fully considered, informed choice on the part of the patient.
- 5.56 The OFT considers that the exercise of an informed choice in this context is especially important given recent research evidence to suggest that clinical performance may vary substantially between different consultants/consultant teams.¹⁶²
- 5.57 The OFT has heard from a number of stakeholders outlining how an increased emphasis on the provision of comparable clinical information in some specialities, such as cardiothoracic surgery, has enabled a step change in quality by providing a measure by which consultants can benchmark their performance against others and a means by which patients can make informed choices and thereby drive competition between consultants.
- 5.58 The OFT considers that the current lack of access to standardised, comparable information on the quality or clinical performance of consultants weakens the ability of patients and GPs to stimulate

¹⁶¹ OFT patient interviews, at page 27, reported that: 'Where GPs did make recommendations, clear reasoning was not always provided and participants did not always know why a particular Consultant or hospital had been recommended. Where lack of information caused the most confusion was when the GP provided a number of choices, but gave no information about what differentiated one Consultant from the other. In such a situation, participants did not see a benefit in being provided a choice'.

¹⁶² A recent study indicating such variability is: 'Variation in reoperation after colorectal surgery in England as an indicator of surgical performance: retrospective analysis of Hospital Episode Statistics', Burns et al, BMJ 2011; 343:d4836

competition between consultants and drive performance standards and quality overall.

- 5.59 In addition, the OFT considers that, in line with the ongoing patient choice agenda,¹⁶³ access to more standardised, comparable information on consultants would be beneficial to inform discussions between GPs and their patients. This is especially the case given that forty-one per cent of GPs do not see it as their role to simply mandate their patients towards a particular consultant.¹⁶⁴
- 5.60 The OFT believes that variability in the use of fee estimates by consultants may also harm PMI funded patients by preventing them from obtaining a prior warning of a potential shortfall from their PMI provider and the option to find an alternative consultant who charges within PMI fee schedules.
- 5.61 Additionally, in relation to the possibility that a patient might be willing to agree a top-up payment with a consultant prior to treatment, without greater information regarding the quality of care being offered by the consultant (either in that specific treatment episode or historically), a PMI funded patient has little ability to establish whether a consultant's higher fee represents higher quality of care and is thus a price worth paying over and above the limits permitted under the patient's PMI fee schedule (further issues relating to PMI fee schedules are considered in the following section).

The information role of PMI providers

PMI provider advice to patients

- 5.62 In addition to GPs, PMI providers can play a role in advising insured patients of their treatment options. Some PMI funded patients expect their PMI provider to provide advice on their choice of provider.¹⁶⁵ The

¹⁶³ For a brief overview of patient choice initiatives, see: Cooperation and Competition Panel, *Review of the operation of 'Any Willing Provider' for the provision of routine elective care*, (July 2011) at pages 9-11

¹⁶⁴ OFT GP survey, at page 19 (2.2.5)

¹⁶⁵ OFT patient interviews, page 42

OFT's GP survey also shows that 16 per cent of GPs identified a patient's PMI provider as the most important influence on the choice of PH facility and/or consultant,¹⁶⁶ and around 20 per cent believed that the choice of facility or consultant was suggested by the PMI provider.¹⁶⁷

- 5.63 In their submissions in this market study, however, PMI providers indicated to the OFT that they did not possess sufficiently detailed information on the quality of care offered by consultants recognised by them¹⁶⁸ and were in most instances unable to advise patients beyond information relating to the consultant's speciality and location.
- 5.64 PMI providers' submissions to the OFT have indicated that affordability is a key issue for customers choosing to purchase PMI, and PMI providers therefore seek effective controls over prices charged by consultants to limit PMI premium rises.
- 5.65 In the absence of price sensitivity on the part of PMI funded patients,¹⁶⁹ PMI providers have a significant role in constraining the costs of PH, in order to limit rises in premiums to maintain affordability and, as a result, can ensure the sustainability and growth of the PH market.
- 5.66 Patients may rely on PMI providers to advise on fees charged by consultants at the pre-authorisation stage,¹⁷⁰ especially as this is an aspect of treatment that many GPs do not consider that they have a role

¹⁶⁶ OFT GP survey, page 27

¹⁶⁷ OFT GP survey, page 25

¹⁶⁸ As noted at paragraph 5.37 above, few consultants submit clinical outcomes or complications data to PMI providers. In the main, PMI providers' recognition criteria rely on the decisions of other organisations (the NHS employer and the GMC) to ensure the consultant is fit to be recognised.

¹⁶⁹ OFT patient interviews, pages 37-8

¹⁷⁰ Prior to obtaining treatment, PMI funded patients may contact their PMI provider to seek preauthorisation of the choice of PH facility and consultant in order to check that they are both recognised by the PMI provider. Preauthorisation is not however mandatory.

in (and patients would not expect them to advise on this¹⁷¹). If contacted by the patient in advance, PMI providers may try to limit the patient's (and their own) exposure to additional fees by providing the following information:

- whether the prospective consultant has historically charged above the PMI provider's fee schedule, or if the fee estimate the patient has been given is above the PMI provider's fee schedule (such as Bupa's 'Benefit Maxima'¹⁷²).
- if the consultant fee rate is 'capped' by the PMI provider.

5.67 These and other methods by which PMI providers attempt to control the costs of PH are reviewed below.

PMI provider attempts to control consultants' costs

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

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

¹⁷¹ OFT patient interviews, at page 38, where no patient interviewed discussed costs with the GP.

¹⁷² Given Bupa's share of the market for PMI, its published benefit maxima is often considered to be the industry standard in terms of reimbursement rates. See OFT consultant survey, pages 69-70 which illustrates how many consultants base their fees on Bupa's benefit maxima.

Managed care

- 5.70 Submissions and evidence from consultants and medical associations have described a practice whereby the PMI provider may become more actively involved in their policyholders' care. This extra involvement may range from influencing the choice of consultant by way of requiring 'open referrals' from GPs, to the provision of a detailed clinical pathway that the consultant should adhere to when providing treatment.
- 5.71 The benefits to the PMI provider of exerting more control over the patient's treatment options (and critically, the identity of the treating consultant) is that it can control costs to a greater degree, perhaps guaranteeing that medical fees fall within the level at which it normally reimburses in full.¹⁷³
- 5.72 However, the OFT has also received submissions from consultants, medical associations and PH providers which allege that the practice of managed care by PMI providers has resulted in inappropriate referrals to consultants who are not sufficiently experienced or specialised to treat the PMI funded patient's particular condition. These submissions have included specific examples where re-referrals to another consultant were subsequently seen. PMI providers have told the OFT that such instances are rare.
- 5.73 The OFT has not investigated this issue fully given that it would be wholly inappropriate to make clinical judgments as to how appropriate (or not) the original referrals may have been. However, it has raised this issue with the FSA and the Financial Ombudsman Service (the Ombudsman) who have confirmed that consumers should make complaints regarding inappropriate referrals in the first instance to the firm, and then, should they remain dissatisfied, to the Ombudsman.¹⁷⁴

¹⁷³ The OFT understands that some PMI providers may operate more varied schemes such as co-payment.

¹⁷⁴ The Ombudsman has produced an example of a relevant complaint (and others in relation to PMI) and its resolution in Ombudsman News issue 77 (May/June 2009) - see www.financial-ombudsman.org.uk/publications/ombudsman-news/77/77-medical-insurance.html. The FSA will monitor this issue and take action if required.

5.74 However, it appears that at least some outcomes may be associated with the lack of consultant quality information currently available to private patients (especially more basic volume information on number and type of procedures undertaken). The OFT believes that the likelihood of such inappropriate referrals would be minimised if patients could see which types of procedures a consultant had carried out over a certain time frame.

Capping of consultants

5.75 Many of the complaints received by the OFT from consultants and medical associations relate to some PMI providers' practice of capping consultants' fees. Evidence submitted to the OFT indicates two main sorts of 'capped' consultants:

- **Capping of new consultants** whereby new consultants, as a condition of being granted recognition by a PMI provider, must set their fees within the PMI fee schedules and give assurances that they will not pursue the PMI funded patient directly for any shortfall
- **Capping of consultants at customary levels** whereby consultants who regularly submit fees over a specific amount are capped at an average level although they are still free to charge PMI funded patients directly for the shortfall incurred between their fee and this average level.

5.76 Complaints received by the OFT from consultants have stressed that the PMI providers' practice of capping and not allowing consultants to seek top-up payments is unfair, arbitrary, and risks forcing consultants out of the market or reducing the supply of consultants available to treat privately funded patients.

5.77 The OFT understands the complaints of new consultants, however, the OFT also believes that the lack of any other method by which to

distinguish the entire population of consultants on the basis of quality means that PMI providers have little alternative criteria on which to base their cost control measures.

- 5.78 This view also extends to more established consultants being capped at customary levels, where, without demonstrable information relating to clinical performance, PMI providers are constrained from entering into informed individual negotiations with these consultants in order to resolve conflicts over regular shortfalls to patients.
- 5.79 In general, price or fee caps are capable of distorting supply in markets. Low price caps may result in an under supply as there may be insufficient incentives for consultants to enter the market. They may also result in an under provision of quality that some patients may prefer. On the other hand, high price caps can generate incentives for consultants to price at the cap level, particularly where prices may be a proxy for quality.
- 5.80 Overall, while price or fee caps are, in principle, capable of distorting supply in markets, the OFT has not seen evidence to suggest that the supply of consultants has been affected.¹⁷⁵

Fee schedules

- 5.81 Most PMI providers publish fee schedules which establish the maximum level at which they will reimburse the consultant for a specific procedure. Consultants who wish to charge more than this schedule will have to charge top-up fees directly to the patient.
- 5.82 Previous considerations by the MMC in 1994¹⁷⁶ and the OFT in 1999¹⁷⁷ on how PMI providers reimburse consultants found that Bupa's benefit

¹⁷⁵ Conversely, fifty-eight per cent of currently practicing consultants surveyed have spare capacity. The OFT consultant survey, figure 3.49 page 48. Additionally, evidence from PMI providers has not shown a sharp downturn in the number of new consultants seeking PMI recognition (albeit at a 'capped' rate)

¹⁷⁶ Competition Commission, *Private Medical Services: A report on agreements and practices relating to charges for the supply of private medical services by NHS consultants* (Cm 2452) (1994) available at: www.competition-commission.org.uk/rep_pub/reports/1994/348privmedical.htm#summary

maxima represented downward pressure on consultant fees in a market where consultants are relatively unconstrained in the prices they set.¹⁷⁸

5.83 Top-up fees are also a more flexible tool for controlling PMI costs as, in principle, they allow those patients who wish to pay a consultant fee above the PMI fee schedule, in return for higher quality treatment to do so. However, the OFT considers that the lack of access to standardised, comparable information about quality of care provided by consultants makes it difficult for PMI providers to control costs in ways that might be more flexible such as top-up fees or more graduated consultant fee structures.

5.84 Ultimately, current information asymmetries in relation to quality and price of consultants may be preventing the development of more sophisticated methods for controlling costs and judging trade offs between cost and quality. For PMI providers, this results in the use of blunt tools for cost control such as capping, and for PMI funded patients, this results in an inability to evaluate whether a potential top-up payment offers value for money and is worth paying.¹⁷⁹

Provisional findings: information asymmetries

5.85 The OFT considers that there is a shortage of accessible, standardised and comparable information provided to patients, GPs and PMI providers in relation to the quality of PH facilities and of consultants. There also appear to be difficulties for PMI funded patients in assessing the risk of shortfall from particular consultants, whereby a consultant's fees exceed the benefit maxima that the patient's PMI provider will reimburse

¹⁷⁷ A press release for this study can be accessed at: www.of.gov.uk/shared_of/market-studies/40_99.pdf

¹⁷⁸ '...we find that the setting of the BUPA benefit maxima is a legitimate step by BUPA in carrying out its functions as an insurer. Insurers must be able to inform policyholders of the benefits they will receive if they claim for events that are covered by their policies. BUPA and the other insurers are the principal counterweight to the consultants, given the weak position of patients. The BUPA benefit maxima have had a restraining effect on consultants' charges.', paragraph 1.11

¹⁷⁹ As described at paragraph 6.61

resulting in the potential for an additional payment by the patient. In addition, for self-pay patients, there are difficulties in easily comparing the prices charged by different PH facilities.

- 5.86 In general, the OFT considers that this shortage of accessible, standardised and comparable information weakens the ability of patients and GPs to drive efficiencies and stimulate enhanced competition between rival PH facilities and between consultants, and may give rise to a dampening of competition in the market overall. The lack of access to information on quality and price for consultants produces a situation where both the patient and PMI provider cannot differentiate between consultant performance and fees in order to judge whether they represent value for money. This may be preventing the development of more flexible, less distortive methods for PMI providers to control consultant costs, whereby patients can choose between consultants on the basis of their respective fees and quality and pay a top-up fee to the consultant, above the maximum provided by their insurance cover, if a patient judges it to be worthwhile.
- 5.87 Finally, the OFT notes that information asymmetries are a factor across a number of other problems examined in this report which are examined in chapter 6. This lack of access to comparable quality information on PH facilities may also help create a competitive dynamic whereby competition between PH providers is based less on the quality of services provided to patients, and since a consultant often chooses at which PH facility the patient is treated, more on attracting consultants to their PH facilities through the use of a variety of contractual and non-contractual incentives. This may increase the cost of PH without necessarily driving improvements in the quality of services provided to patients. The development of consultant incentives is examined in chapter 8.

6 CONCENTRATION IN PRIVATE HEALTHCARE PROVISION

Introduction

- 6.1 This chapter examines concentration in the PH market. Market concentration is concerned with the 'number and size distribution of firms in a particular market. It is generally accepted that, other things being equal, the larger the market share of a firm, the greater its market power is likely to be, particularly if its high market share has persisted over a period of time and is relatively stable'.¹⁸⁰
- 6.2 In line with the likely relevant geographic market definition,¹⁸¹ the chapter begins with an assessment of the concentration of PH providers at the national level. The following section then examines concentration at the local level. The OFT's analysis in this market study indicates that there is concentration of PH provision at the national level, and high concentration of provision in some local markets. This may allow PH providers to exercise a degree of market power.
- 6.3 This chapter also considers the concentration of purchasers of PH and in particular the significance of the interaction between PMI and PH providers. The OFT's analysis indicates that there is a degree of concentration on the demand side of the PH market and PMI providers may have a degree of buyer power, albeit that there are constraints on the ability of PMI providers to exercise any such buyer power. These constraints arise in part from the limited ability of PMI providers to direct PH patients to different PH providers – an issue that, as noted in the chapter 5, is linked to the limited information on quality available to PH patients.
- 6.4 The final section therefore examines the nature of the relationship between PH and PMI providers in the PH market.

¹⁸⁰ Market Investigation References: Guidance about the making of references under Part 4 of the Enterprise Act, March 2006, page 26.

¹⁸¹ As noted in the chapter 4 of this report, the OFT considers that the geographic market is likely to be both national and local in nature. There are also potentially some regional aspects to competition.

6.5 This chapter also examines some recent developments in the PH market. In particular, the OFT considers the impact that PPU partnering and recent policy initiatives by the larger PMI providers may have on concentration in local markets.

6.6 This chapter has four main sections. These are:

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

Concentration of PH providers at the national level

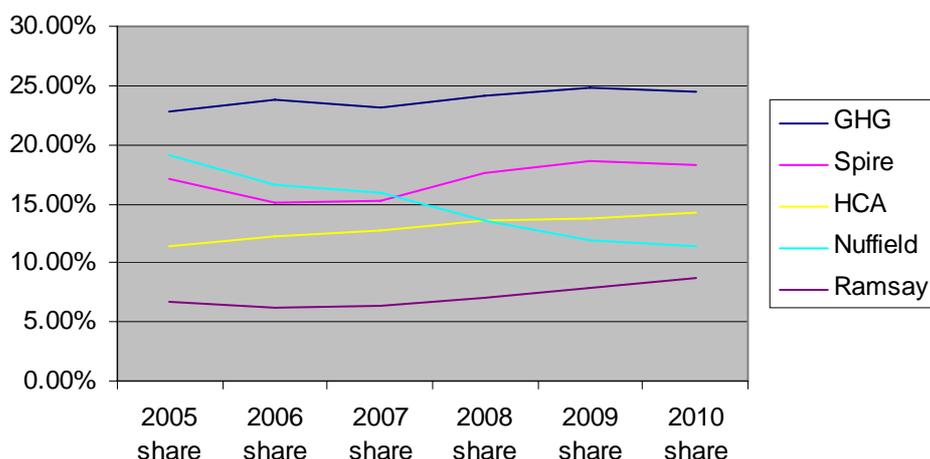
6.7 As discussed above in chapter 4, it appears that there are national elements to competition across the PH market as this is the level at which negotiations between PH and PMI providers takes place, including the annual negotiations to agree the prices of treatments and the negotiations regarding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

6.8 It can be seen from Table 6.1 below that the combined market share based on revenues of the five largest PH providers was approximately 77 per cent in 2010. As can be seen from figure 1 below, the market shares of four of the five largest PH providers have remained relatively stable over the period 2005 to 2010.

Table 6.1: National PH market shares by value, 2005 to 2010¹⁸²

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

Figure 6.1: Market shares for the five largest PH providers over the period from 2005 to 2010¹⁸³



6.9 Figure 6.1 above shows that GHG, Spire, HCA and Ramsay have all experienced growth over the period 2005 to 2010, although Spire experienced a temporary fall in their market shares in 2006 and 2007

¹⁸² Source: Data supplied by Laing & Buisson. The data excludes centrally procured ISTC activity and diagnostics for the NHS provided by specialist diagnostic providers. Notes: Classic Facilities was part of Bupa Facilities until its sale to L&G Ventures in July 2005. Spire bought out Bupa Facilities in August 2007 and acquired Classic Facilities in February 2008.

¹⁸³ Data supplied by Laing & Buisson. The data excludes centrally procured ISTC activity and diagnostics for the NHS provided by specialist diagnostic providers. Notes: Classic Facilities was part of Bupa Facilities until its sale to L&G Ventures in July 2005. Spire bought out Bupa Facilities in August 2007 and acquired Classic Facilities in February 2008.

and GHG experienced a slight fall in 2007. Nuffield's market shares have been declining during this period from 19 per cent in 2005 to 11 per cent in 2010. This could in part be due to a reduction in the number of PH facilities owned by Nuffield following the sale of nine of their PH facilities to GHG in 2008.

6.10 In the context of this market study, the OFT has calculated a Herfindahl-Hirschman Index (HHI)¹⁸⁴ for the national PH market using the market shares of the top eight providers outlined in table 6.1 above. These values are set out in Table 6.2 below.

Table 6.2: National PH market HHI values, 2005 to 2010¹⁸⁵

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

6.11 In the OFT and CC Joint Publication, *Merger Assessment Guidelines*,¹⁸⁶ a market in which the HHI exceeds 1,000 is categorised as 'concentrated' and one in which it exceeds 2,000 is categorised as 'highly concentrated'.

6.12 The indices set out at Table 2 suggest that there was a decrease in national PH market concentration between 2005 and 2007, with a small

¹⁸⁴ The HHI is a measure of the size of firms in relation to the industry. The index increases with concentration and ranges from zero (a very fragmented market) to 10,000 (a single supplier).

¹⁸⁵ Source: OFT calculations, based on data supplied by Laing & Buisson. The data excludes centrally procured ISTC activity and diagnostics for the NHS provided by specialist diagnostic providers

¹⁸⁶ OFT and CC Joint Publication. *Merger Assessment Guidelines*, 2010. Available at: www.of.gov.uk/shared_of/mergers/642749/OFT1254.pdf

increase thereafter until 2009. However, the national PH market would be categorised as 'concentrated' throughout the period.

Concentration of PH providers at the local level

6.13 Concentration of PH providers at the local level varies across the UK. Within the timetable of this market study, the OFT has not sought to assess the concentration of all potential individual local PH markets in the UK. However, the OFT has looked at PH facilities described as solus and PH facilities described as 'must have' in seeking to understand the possible local market dynamics in the PH market. The analysis below considers solus PH facilities, where there is no alternative PH facility within a 30 minute drive time before moving on to examine 'must have' PH facilities.¹⁸⁷

Solus facilities

6.14 PH facilities that have no competing fascia within a 30 minute drive time of the PH facility are described as solus.¹⁸⁸ This definition has been adopted in previous CC and OFT merger cases.¹⁸⁹ By definition, using HHI as the measure of concentration, an area with one PH facility would be considered highly concentrated.

¹⁸⁷ As discussed in the Market Definition chapter of this market study report, the use of drive time isochrones is considered to be an appropriate way of assessing local PH markets.

¹⁸⁸ British United Provident Association Limited and Community Facilities Group Plc: A report on the proposed merger; and British United Provident Association Limited, Salomon International LLC and Community Facilities Group Plc; and Salomon International LLC and Community Facilities Group Plc: A report on the existing mergers, December 2000. Available at: www.competition-commission.org.uk/inquiries/completed/2000/index.htm#bupa

¹⁸⁹ These are: (i) Completed acquisition by General Healthcare Group of control of four Abbey hospitals and de facto control over Transform Holdings Limited previously part of the Covenant Healthcare Group, October 2010; (ii) Completed acquisition by Spire Healthcare Limited of Classic Hospitals Group Limited, July 2008; (iii) Completed acquisition by General Healthcare Group of assets of Nuffield Facilities, May 2008; and (iv) British United Provident Association Limited and Community Facilities Group Plc: A report on the proposed merger and British United Provident Association Limited, Salomon International LLC and Community Facilities Group Plc; and Salomon International LLC and Community Facilities Group Plc: A report on the existing mergers, December 2000.

- 6.15 A few PMI providers have commented in submissions to the OFT that, while the use of 30 minute drive time isochrones is appropriate for the determination of a solus facility, such an approach, if used alone, would not identify all PH facilities that have potential market power.
- 6.16 As noted at paragraphs 4.35 to 4.37, a 30 minute drive time isochrone is a useful proxy for defining local PH markets, and has advantages over other potentially more sophisticated techniques such as critical loss analysis.¹⁹⁰ It is possible that the application of such isochrones may under or over estimate the size of the local market that some PH facilities operate in. However, given the timescale of this market study, the range of local markets analysed, and the extensive data requirements necessary to undertake other analyses of local markets, the OFT considers that an isochrone analysis is appropriate to analyse local competition for the purposes of this market study.
- 6.17 In addition, a PH facility that is not solus might nevertheless hold market power as a result of unique attributes it has in the local market, such as size or availability of equipment. PMI providers describe these PH facilities as 'must have' and these are examined below.

'Must have' PH facilities

- 6.18 The term 'must have' is used by some PMI providers to refer to PH facilities which are not solus but which PMI providers consider they need to provide access to in terms of providing sufficient PMI coverage across its customer base.
- 6.19 Some PMI providers consider that a PH facility is 'must have' if one or more of the following circumstances arise:
- it is the only PH facility in a local area that provides a particular specialism or procedure, in which case the PMI provider may have no choice but to recognise the PH facility if it is to offer policyholders sufficient access to the specialism or procedure in that local area

¹⁹⁰ This is because critical loss analysis assumes that patients are price sensitive.

- other PH facilities in the local area do not have sufficient capacity and, as such, PH patients could not be diverted away from the PH facility
- a large proportion of the PMI provider's spend in a local area is with that PH facility.¹⁹¹ This is because it is likely that the PMI provider would face significant redirection costs if they were to remove that particular PH facility from their PMI network. Redirecting policyholders in this way may, for example, have reputational risks for the PMI provider due to the inconvenience caused to its policyholders from being redirected to an alternative PH provider.

6.20 Due to their different circumstances,¹⁹² a PH facility may be considered 'must have' by one PMI provider but not by another. It is likely that some areas that contain 'must have' PH facilities would be considered concentrated using HHI as the measure of concentration.

The number of solus and 'must have' PH facilities in the UK

6.21 Table 6.3 below sets out estimates for the number of solus and 'must have' PH facilities in the UK. The number of solus PH facilities in the UK has been identified by the PH providers and PMI providers and the number of 'must have' PH facilities is based on the submissions received from PMI providers.

¹⁹¹ This spend relates to PMI providers reimbursing facilities for the cost of treatment on behalf of their policyholders, as mentioned in chapter 3.

¹⁹² These different circumstances may relate to, for example, the number of policyholders the PMI provider has in the particular area or the proportion of the PMI provider's spend in the local area that is with a particular PH facility, which will be unique to the individual PMI provider.

Table 6.3: Number of Solus and 'Must Have' PH Facilities owned by the five largest PH providers in 2011¹⁹³

	Total
2011	
Number of Solus PH Facilities¹	27
Number of Solus and 'Must Have' PH Facilities²	66

6.22 The map below shows the locations of the 27 solus and 39 'must have' PH facilities identified which are owned by the five largest PH providers. The data provided in Table 6.3 above and the map relates to those PH facilities identified by PH and PMI providers, based on the definitions outlined above. Whilst this methodology may give an indication of the number of solus and 'must have' PH facilities in the UK, the OFT acknowledges that the identification of 'must have' PH facilities is based on the judgements of different PMI providers rather than on an objective methodology, and therefore there may be different views on whether one facility is identified as 'must have' or not. This is because, as discussed above at paragraph 6.20, the nature of 'must have' PH facilities means that a PH facility may be 'must have' for one PMI provider but not for another. Nevertheless, this methodology is considered by the OFT to be sufficient to gain a useful indication of the number and location of solus and 'must have' PH facilities owned by the five largest PH providers.

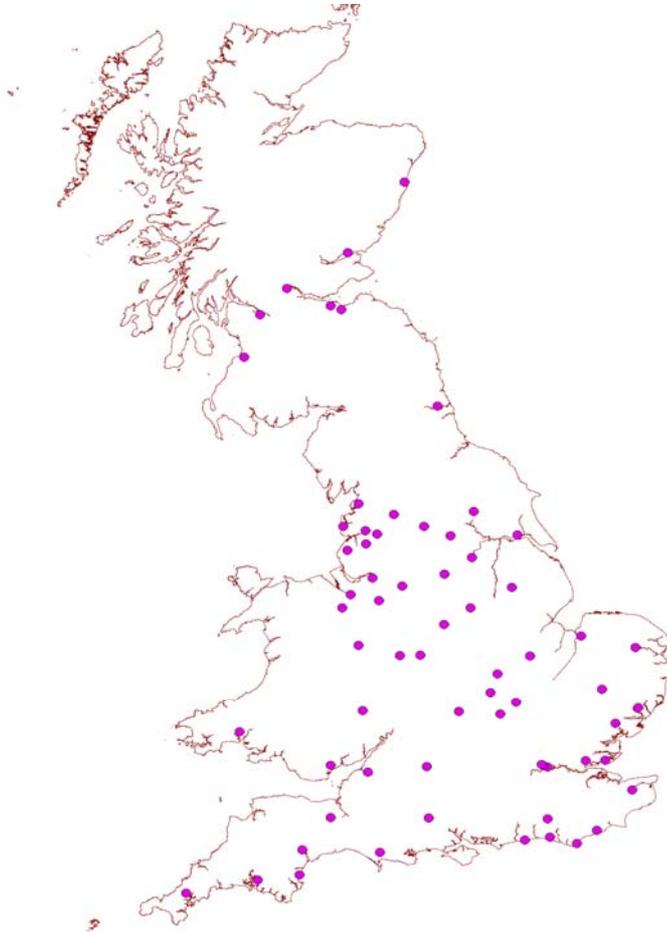
6.23 The map shows that the solus and 'must have' PH facilities are spread across the UK, although there appears to be more solus and 'must have'

¹⁹³ Source: OFT analysis of data provided in response to the OFT's general information request by PH providers and PMI providers.

Notes on table: 6.3: 1) The number of solus facilities, as identified by PH and PMI providers owned by the five largest PH providers. 2) The number of solus and 'must have' facilities identified by PMI providers and PH providers, owned by the five largest PH providers. Facilities are included if they are identified by at least one of the PMI providers as being either solus or 'must have' or by the PH providers themselves as being solus. PMI and PH providers, in their submissions to the OFT, were largely consistent in their identification of solus PH facilities.

PH facilities in the South of England and in the Midlands, extending to Leeds.

Figure 6.2: Map of the solus and 'must have' PH facilities¹⁹⁴



The importance of solus and 'must have' facilities and their impact on the PH market

6.24 The OFT patient interviews found that, in general, patients' primary concern when considering a choice of PH facility was to be treated locally.¹⁹⁵ As a consequence, PMI providers recognise PH facilities all over the UK and create networks that provide nationwide coverage in

¹⁹⁴ Source: OFT mapping based on submissions received from PH providers and PMI providers

¹⁹⁵ OFT patient interviews, page 47

order to provide policyholders access to PH facilities in their local area. PMI providers also indicated to the OFT that policyholders, although wanting to be treated close to home, often also value a policy that offers nationwide coverage.¹⁹⁶

- 6.25 In addition, corporate clients¹⁹⁷ that have employees across the UK, in particular, are likely to value a PMI policy that offers nationwide coverage.
- 6.26 In order to offer nationwide coverage, it would appear that PMI providers have to contract with all of the larger PH providers, as they each own a number of solus and/or 'must have' PH facilities. As such, PMI providers appear to be dependent on the larger PH providers, as owners of solus or 'must have' facilities, in order to provide the nationwide coverage valued by PH patients.
- 6.27 PMI providers have suggested that the ownership of solus and 'must have' PH facilities allows PH providers to leverage a degree of market power when negotiating in relation to recognition for all of their PH facilities. This is considered further in chapter 8.
- 6.28 A number of PMI providers have also stated that whether a PH facility is considered to be solus or 'must have' affects the price of treatments charged by the PH providers for treating the PMI provider's policyholders.¹⁹⁸
- 6.29 During this market study, the OFT requested data from PH and PMI providers with a view to undertaking a detailed assessment of whether

¹⁹⁶ This is also supported by one of the larger PH providers, which notes that in order to be able to sell PMI policies, PMI providers need to have access to a number of PH facilities across the country that can provide PH in the areas where their customers live and work.

¹⁹⁷ As mentioned above in chapter 3, 69 per cent of PMI sales in 2009 were to corporate clients.

¹⁹⁸ A number of economic studies of private health markets in the US and Netherlands have found a positive relationship between levels of local PH concentration and the prices/margins charged by providers. Similarities between these markets and the UK PH market may be indicative of a similar relationship in the UK although the OFT does not draw any definitive conclusions in this regard.

the price charged by PH providers for treating the PMI providers' policyholders at specific PH facilities was impacted by the level of concentration in the relevant local area. However, although all stakeholders did provide data, this data did not provide a sufficiently robust basis on which to compare pricing at different PH facilities. The OFT has not undertaken, therefore, a related comparative analysis. This is a matter which the CC may wish to investigate further, if it is minded to do so.

- 6.30 The OFT has also attempted to consider whether the service quality of specific PH facilities is impacted by levels of local market concentration. This is because where local market concentration is high, one might expect PH providers to be under less competitive pressure to increase their service quality. In the absence of published, comparable information on service quality, the OFT has assessed whether solus and 'must have' PH facilities are more or less likely to be refurbished by way of a preliminary proxy for such an assessment.
- 6.31 Data relating to all refurbishment projects over £1 million undertaken over the period 2007-2010 was provided by some, but not all, of the larger PH providers. The data provided some limited evidence that solus and 'must-have' PH facilities were less likely than other PH facilities to have been refurbished between 2007 and 2010. As with the pricing comparison outlined at paragraph 6.29 above, the underlying data is limited, and the OFT did not progress this analysis further; and indeed did not consider further analysis critical to its findings.

Conclusion on solus and 'must have' facilities

- 6.32 Based on the preliminary analysis of solus and 'must have' PH facilities it appears that PMI providers are dependent on the larger PH providers, who all own solus and/or 'must have' PH facilities, and this may give the larger PH providers a degree of market power.
- 6.33 However, PH providers have stated that the ownership of solus PH facilities does not confer any form of market power on PH providers because the size and importance, in terms of a source of revenue, of the larger PMI providers make them essential business partners for the PH providers. This potential buyer power of PMI providers is considered in the following section of this chapter.

Scale and buyer concentration of PMI providers

6.34 PMI funded patients account for approximately 60 per cent of revenue generated by PH providers, on average.¹⁹⁹ NHS patients account for approximately 25 per cent and self-pay patients²⁰⁰ for the remainder.

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

- individual PMI providers
- the NHS,²⁰¹ and
- self-pay patients.

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

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

¹⁹⁹ As discussed in the chapter 3 of this report. Source: Laing & Buisson, *Laing's Healthcare Market Review 2010-11*.

²⁰⁰ Including self-pay patients from overseas.

²⁰¹ As noted in chapter 2, the OFT does not consider that publicly funded, privately provided services are within the scope of this market study, or within the scope of the relevant market. Nevertheless, we do consider that it is relevant to assess the NHS as a source of revenue for PH providers since it impacts on the degree to which PH providers are dependent on PMI providers as a source of revenue.

Table 6.4: Buyer side shares of the value of PH purchases, 2009 ²⁰²

Purchaser of PH	Market Shares %
Bupa	25.1
AXA PPP	15.5
Aviva	6.3
PruHealth	6.0
WPA	1.7
Other PMI providers	5.4
NHS	24.7
Self-pay	15.3

- 6.38 Table 6.4 shows there is a degree of concentration of purchasers of PH.²⁰³ The larger PMI providers account for a large share of demand for PH, suggesting they may have a degree of buyer power.
- 6.39 In addition, the figures presented above in table 6.4 may under-estimate the importance of the larger PMI providers to the viability of the PH providers. PH providers have stated that PMI funded patients are significantly more profitable compared to NHS patients and NHS patients are usually only treated to use spare capacity, such as theatres and beds, when otherwise these would be empty. One PH provider has stated that treating NHS patients is usually carried out to make a contribution to fixed costs already incurred (such as staff and theatre equipment) when otherwise there would be none. This is also supported by financial data, supplied by some of the PH providers and analysed by the OFT, which shows revenue earned from treating NHS patients often

²⁰² Source: OFT analysis of data presented in Laing & Buisson, figure 2.4 and table 3.12. Notes: 'Self-pay' includes overseas patients that self-pay.

²⁰³ It is important to note that self-pay patients purchase PH individually and not as a group so this portion of the market should not be viewed as a buying group. Similarly, NHS purchases of capacity from PH providers tend to be made by individual NHS trusts. PH providers treat publicly funded patients on the same terms as an NHS trust would treat a publicly funded patient and are paid the same price, which is determined according to the NHS tariff and set by the Department of Health.

did not appear to cover all costs associated with treating NHS patients.

²⁰⁴

- 6.40 The majority of PH providers told the OFT that they would find it very difficult to remain economically viable if they were not included on the facility networks of the major PMI providers. In particular not being on the larger PMI providers' networks would undermine the viability of a PH facility
- 6.41 This is further supported by Laing & Buisson, who report that 'not being included on Bupa and/or AXA PPP's networks could mean a significant shortfall in demand' for PH providers.²⁰⁵ PH providers consider that this criticality provides the PMI providers with a strong starting negotiating position during the annual contract negotiations between PMI and PH providers.
- 6.42 The evidence, while suggesting that the larger PMI providers may be key trading partners for the PH providers, also indicates that there may be limits on the ability of the PMI providers to exercise countervailing buyer power. These limits are considered below.

An assessment of market power

- 6.43 Markets that have concentration on both the supply side and the demand side are often characterised by bargaining between suppliers and purchasers over the terms of supply (price, volume, duration of contract, degree of exclusivity). The relative bargaining strength of each negotiating party depends on a number of factors, for example the degree to which one party is dependent on the other to be economically viable, or whether there are credible outside options in terms of, for example, alternative suppliers or customers.
- 6.44 In this respect, because of the presence of solus and 'must have' PH facilities in a number of local areas, a PMI provider may not have credible alternative supply options in these areas. This may limit the ability of

²⁰⁴ In these cases, while a profit was made relative to treatment and building costs, only a contribution was made towards administrative and overhead costs.

²⁰⁵ Laing & Buisson, Laing's Healthcare Market Review 2010-11, pages 71-72

PMI providers to exercise countervailing buyer power in contract negotiations with PH providers, including the annual negotiations relating to the price of treatments.²⁰⁶

- 6.45 Further, it may be costly for PMI providers to remove PH facilities from their network, especially solus and 'must have' PH facilities. PMI providers state that removal of a PH facility could have reputational costs and lead to possible complaints to the Ombudsman as some policyholders may no longer consider their policy fit for purpose. PMI funded patients may also face costs associated with moving PH facility mid-treatment particularly if their consultant is unable to move with them or the inability to re-insure existing medical conditions with a PMI provider that does offer access to the PH facility at which the patient has previously been treated. Therefore, PMI providers may find it difficult to switch to alternative PH providers in certain local areas.
- 6.46 Once a PH facility is included on its network, a PMI provider's buyer power may be further constrained by the limited ability of the PMI provider to direct patients' choices of PH facility, and thereby steer patient volumes between different facilities on the network. As noted in chapter 5, the patient's choice of PH facility is often determined by the patient's consultant, and in the absence of comparable information on the quality of different PH facilities it can be difficult for PMI providers to influence patient choices to ensure value for money.
- 6.47 At the national level, it is also claimed by PMI providers that once a PMI provider has included a PH provider's portfolio of facilities on its network it would be difficult to remove that PH provider group from the PMI provider's network entirely. This is because the scale of the larger PH providers' portfolios of PH facilities appears to make it difficult to direct PMI funded patients away from all of the PH provider's facilities.
- 6.48 This may limit the PMI providers' buyer power as it appears to reinforce the need for PMI providers to continue to contract with all of the larger PH providers. This is supported by internal strategy documents submitted to the OFT by one of the larger PH providers, which indicates

²⁰⁶ As table 6.3 shows above, there are approximately 66 solus and 'must have' facilities across the UK.

that increasing the number of facilities owned by the PH provider is important in improving their negotiating position with purchasers of PH, such as with PMI providers during the annual price negotiations and the negotiations regarding at which of the PH provider's PH facilities the PMI provider's policyholders can be treated.

- 6.49 The OFT has also considered levels of regional concentration in relation to the exercise of buyer power by PMI providers, as some submissions from PMI and PH providers have commented that there are regions of the UK that have become increasingly concentrated in relation to the provision of PH.
- 6.50 The OFT considers that in areas where there are a number of solus and/or 'must have' PH facilities owned by a single PH provider it may be particularly difficult for an individual PMI provider to switch to an alternative PH provider in that region. This may be particularly an issue for PMI providers' offerings to corporate clients which are based in particular regions.
- 6.51 One such area that is raised by a number of PMI and PH providers is London. Some stakeholders have claimed London contains a number of 'must have' facilities which are owned by one PH provider which places that PH provider in a particularly strong negotiating position. In order to have an attractive policy for certain corporate clients, PMI providers state that they need to provide access to these PH facilities. However, one PH provider has claimed that London is a highly competitive and fragmented market environment and as a result PMI providers are in a strong position when negotiating with hospitals in London and the South-East
- 6.52 The evidence discussed above indicates that while the larger PMI providers are significant purchasers of PH, there are limits on their ability to exercise buyer power, such that their buyer power appears to not be countervailing. These limits derive primarily from two factors:
- the need for PMI providers to offer PMI policies covering the provision of PH in most, if not all, local markets, some of which contain solus or 'must have' PH facilities
 - the limited ability of PMI providers to direct the choice of PH facilities of their policyholders.

6.53 In addition, the OFT considers that the evidence presented in chapter 8 of certain negotiating strategies on the part of PH providers and contractual provisions imposed by PH providers lends support to a provisional finding that PH providers are likely to possess a degree of market power.

Recent developments

6.54 Recent developments relating to the delivery of PH and the offerings of PMI providers may have an impact on the relationship between PH and PMI providers in the PH market. These recent developments are:

- PPU partnering, and
- new PMI policies, low-cost networks and proposed delisting of a number of facilities by a PMI provider.

PPU partnering

6.55 In this section, the OFT explores the impact on concentration at the local level of PH providers partnering with individual NHS trusts to manage and operate PPUs.

6.56 The OFT has received submissions from both PMI and PH providers commenting that PPU partnering may increase local market concentration in certain parts of the UK, particularly in London and the South East of England.²⁰⁷ On the other hand, such partnering arrangements may offer a low capital cost entry option for new entrants and alternative PH providers in the local market.

6.57 A number of PPUs have entered into partnering agreements with PH providers and this seems to be a growing trend. Currently the OFT is

²⁰⁷ As discussed in the Market Definition chapter of this report the competitive constraint provided by PPUs on other PH providers varies and these partnering arrangements will impact on the competitive constraint offered by the PPUs.

aware of eight PPUs that are managed by PH providers.²⁰⁸ There are also a number of PPU partnering agreements currently out to tender.

6.58 It is apparent that the levels of concentration of some local markets may be affected by these partnering arrangements. Local market concentration may increase if a PH provider that is already present in the local market partners with the PPU that is part of the same local market. This has the potential to reduce competition in the local PH market because the partnering arrangement may remove any competitive constraint on the relevant PH provider offered by the PPU prior to the partnering arrangement and reduce choice for PH patients and PMI providers.

6.59 If the PH provider partner is a new entrant in the market the impact of the arrangement on the local PH market is less clear. If the competitive constraint of the PPU on other local PH providers is increased as a result of the partnering arrangement,²⁰⁹ one possible outcome is improved choice for PH patients and PMI providers. However, this would need to be assessed on a case by case basis.

6.60 Therefore, it is apparent that the concentration of some local markets may be impacted by these partnering arrangements. Whether PPU partnering arrangements should be notified to the OFT as possible mergers is discussed in chapter 9 of this market study report.

New PMI policies, low-cost networks and proposed delisting of a number of facilities by a PMI provider

6.61 During the course of this market study Bupa and AXA PPP have introduced policies with self termed 'low cost networks' which do not

²⁰⁸ Laing & Buisson name the following; HCA Harley Street @ UCH, London; HCA Harley Street @ Queens, Romford; Ramsay Orwell Cardiothoracic PPU, Basildon; Nova Healthcare St James' Institute of Oncology PPU, Leeds; Spire Papworth Hospital Varrier Jones Ward, PPU Cambridge; Interhealth Canada National Hospital for Neurology and Neurosurgery PPU, London. The OFT is also aware of the following PPU partnership as listed on the PH provider's website: HCA Christies, Manchester.

²⁰⁹ As discussed in the Market Definition chapter of this report, the competitive constraint offered by PPUs on other PH providers varies.

include all of the PH providers or all of their PH facilities. PMI providers say that these new PMI policies are niche, lower priced policies aimed at individual policyholders, rather than corporate customers, who are willing to trade choice of PH facility for a lower premium. It is not apparent what impact the introduction of these policies with 'low cost networks' will have on the PH market and the relationship between PH and PMI providers. However, it may be that, by limiting the number of PH facilities on the 'low cost network', PMI providers are attempting to encourage competition between PH providers at a local level for inclusion on the 'low cost network'.

- 6.62 PMI policies which involve the patient obtaining an 'open referral' from their GP (a referral letter that does not name a consultant or PH facility) have also been launched by some PMI providers. As discussed above, PMI providers appear to find it difficult to direct patients away from PH facilities once the consultant has chosen the PH facility at which the patient will be treated. Therefore, the use of open referrals may reduce the difficulties facing PMI providers of directing patients, to some extent, and allow the PMI provider to gain some control over the choice of consultant and/ or PH facility accessed.
- 6.63 In addition, the OFT has been provided with limited details of a PMI provider threatening to delist from its standard network a number of facilities owned by a PH provider. If these facilities were delisted, it would mean that the PMI provider's policyholders that have chosen a product that includes access to the standard network of PH facilities would no longer have access to these PH facilities. The OFT is aware that this action is part of ongoing negotiations between the PH and PMI provider and so it is not clear what the outcome of these current negotiations will be.
- 6.64 Although these recent developments may be capable of limiting any market power that the PH providers may enjoy, it is premature for the OFT to assess the impact that these will have on the relative negotiating strength of the PH and PMI providers.

Provisional findings: concentration

- 6.65 The PH provider market appears to be concentrated at the national level. At the local level there appear to be areas of high concentration, such as

areas where there is no alternative fascia PH facility within a 30 minute drivetime of a PH facility (solus PH facilities), and some local markets with 'must have' PH facilities.

- 6.66 The existence of solus and 'must have' PH facilities means that PMI providers are dependent on the PH providers that own these facilities in order to provide nationwide coverage for their policyholders.
- 6.67 The size of the larger PMI providers appears to result in at least a degree of buyer power in that PH providers are, to some extent, dependent on these larger PMI providers for the financial viability of their facilities. However, there may be limits on the PMI providers' ability to exercise their buyer power for two main reasons. Firstly, buyer power may be constrained by the need for PMI providers to purchase PH in most local markets, including areas with solus and 'must have' facilities as described above. Secondly, since in most cases GPs rather than PMI providers recommend the consultants, and consultants often determine a patient's choice of PH facility, the PMI providers have limited ability currently to direct patients to different PH facilities. Therefore, as the buyer power of the PMI providers appears not to be countervailing, the larger PH providers may have a degree of market power.
- 6.68 The OFT notes that the development of partnership arrangements between PPU's of NHS/Foundation Trusts and PH providers has the potential to either exacerbate or alleviate concentration in local PH markets. Local market concentration may increase if a PH provider that is already present in the local market partners with the PPU. This is because the partnering arrangement may remove any competitive constraint on the relevant PH provider offered prior to the partnering arrangement and reduce choice for PH patients and PMI providers. On the other hand, a partnership arrangement between a PPU and a new PH provider in the local market has the potential to provide a platform for entry and thereby to increase competition. As a result of this market study, the OFT has made a recommendation to the Department of Health and to the NHS/ Foundation Trusts in relation PPU partnering arrangements (see chapter 9).

7 CONCENTRATION OF ANAESTHETISTS

- 7.1 Submissions received during the course of this market study have indicated that there is a growing trend for consultants to form groups. In particular, there is a trend for anaesthetists to form groups (AGs) and this has led to concentration of anaesthetists in parts of the UK.
- 7.2 In a number of local areas, consultants form groups that work to a common fee level. The OFT consultant survey showed that 16 per cent of those who responded were part of a consultant group. Those consultants who were part of a consultant group stated that 'membership brought cost efficiencies through shared resources, gave them a more effective platform for marketing themselves to GPs and PH facilities, and provided access to a wider range of experts and professional opinion'.²¹⁰
- 7.3 The legal structure of consultant groups varies, ranging from legal partnerships to more informal groups that operate joint billing and equal profit sharing. From the evidence submitted, it appears that the observed trend to form consultant groups, both within single PH facilities and across a local area, is especially marked for anaesthetists.²¹¹
- 7.4 Anaesthetists tend to establish working relationships with surgeons, who will arrange for them to treat their patients if necessary for a particular procedure. In many cases, the PH patient may be unlikely to meet their anaesthetist before undergoing treatment, and anaesthetists appear to have little impact on the direction of the patient journey.²¹²
- 7.5 In relation to the specific benefits enjoyed by such groups, the Association of Anaesthetists of Great Britain and Ireland (AAGBI) states that typical benefits for anaesthetists working in such groups would

²¹⁰ OFT consultant survey page 76

²¹¹ Anaesthetists are qualified medical doctors who specialise in pain management, anaesthesia and intensive care medicine. Anaesthetists provide medical care to patients before, during, and after surgical procedures.

²¹² OFT patient interviews, at page 32, indicated limited interaction between patient and anaesthetist.

include the division of administrative costs, shared secretarial support, an increased ability to promote and build a private practice and optimal team working with surgeons which improves patient outcomes. The OFT is also aware that typically AGs set a common fee level for their members.

- 7.6 According to a survey conducted by the AAGBI, around 44 per cent of anaesthetists active in the PH market are involved in an AG. The AAGBI submitted that the number of AGs has grown from 22 in 2006 to over 45 in 2011. This trend coincides with the observation, made by a number of PMI providers, that anaesthetists are the sub-speciality with which the PH patient is most likely to experience a shortfall.
- 7.7 The OFT has received a number of submissions from PMI providers and complaints from patients which indicated that the anaesthetist fees being charged for the relevant treatments received by some patients were not covered in full by the PMI provider and, as such, the patients would face an unexpected shortfall and the patients could not find an alternative local anaesthetist who charged within their PMI provider's fee schedule.
- 7.8 These submissions state that it is difficult for a patient to switch to an alternative anaesthetist. This is because patients will typically only meet their anaesthetist just before their surgery and at this point patients are unlikely to switch to an alternative anaesthetist as this would require postponing their surgery and travelling to an alternative facility located much further away to avoid paying a shortfall.
- 7.9 The OFT has raised with the FSA the issue of whether PMI providers should make the likelihood of consultant shortfalls clear, both at the point of sale and at the time a PMI funded patient makes a claim under their PMI policy (see chapter 9).
- 7.10 Furthermore, PMI providers have provided evidence which demonstrates that in most cases the shortfall rate amongst AGs is higher than the national average shortfall rate for anaesthetists that are not part of an AG, which indicates that anaesthetists that are part of an AG may charge higher fees than those who are not part of an AG.

Provisional Finding

- 7.11 Forty-four per cent of anaesthetists are part of an Anaesthetist Group (AG). Prior to, and during the course of, the market study, the OFT received a number of complaints from patients regarding their inability to find an anaesthetist who will charge within PMI provider fee schedules. These complaints have been supported by submissions and evidence from PMI providers as part of the market study that high concentration of AGs in some local markets may raise prices. In the light of these complaints, the OFT suspects that the prevalence of AG groups is also a feature of the market which may reduce price competition in local markets (particularly in view of switching costs such as the costs associated with postponing treatment or travelling to an alternative facility).

8 BARRIERS TO ENTRY AND EXPANSION

Introduction

8.1 Chapter 6 considered levels of concentration in the PH market and concluded that these appear to confer a degree of market power on PH providers. However, it is unlikely that PH providers will have any lasting market power if there are no significant barriers or impediments to entry in the PH market such that there is a realistic possibility that a new entrant could establish itself in the market within a reasonably short period of time.²¹³

8.2 This chapter therefore examines the barriers to entry in the PH market:

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

8.3 The analysis indicates that there appear to be significant barriers to entry in the PH market. This is supported by evidence that suggests that entry into the PH market has been very limited over time, with only one significant new entrant offering full service PH facilities²¹⁴ in recent years.²¹⁵ This analysis is also consistent with recent merger decisions,

²¹³ *Market Investigation References – Guidance about the making of references under Part 4 of the Enterprise Act*, paragraph 5.10.

²¹⁴ See chapter 3 for a definition of full service PH facilities.

²¹⁵ Other than through acquisition of existing facilities and that new entrant, Circle, is still operating at a loss. In its Interim Report for the six months ended 30 June 2011 Circle Holdings reported an EBITDA loss before exceptional items of £6.8 million (www.circleholdingsplc.com/uploads/document/file/21/circle_holdings_plc_h1_2011_interim_report.pdf).

where the OFT has examined the barriers to entry and expansion in the PH market, and concluded that such barriers are high enough to make the threat of entry insufficient to deter attempts to exploit existing market power.²¹⁶

Capital requirements

- 8.4 Submissions by PH providers to the OFT have explained that a successful new PH facility typically requires a certain level of capital investment to cover its fixed costs. These costs will vary with the size of PH facility and the range of treatments it offers.²¹⁷ Submissions also suggest that sufficient capital is required until a PH facility is financially sustainable and this presents more of a barrier than capital for building.
- 8.5 However, stakeholder submissions also suggest that innovations in technology and clinical practice have led to a move away from treatment in an inpatient setting, as more procedures are conducted on a day case or outpatient basis and, as a result, newer PH facilities, including full service PH facilities, tend to be smaller and have lower capital requirements. (see paragraph 3.24)
- 8.6 'Satellite' PH facilities built by PH providers contain just a few rooms and basic diagnostic equipment and can be located near to a competitor PH facility. The evidence suggests that this lowers the cost of entry into local markets for the larger PH providers, which are then able to channel patients from these smaller diagnostic satellite PH facilities to their full service PH facility²¹⁸ even if the full service PH facility is located further away than a rival PH facility.

²¹⁶ See, for example, Completed acquisition by Spire Healthcare Limited of Classic Hospital Groups Limited, ME/3610/08, 18 June 2008, page 20.

²¹⁷ Estimates vary widely, but a typical figure for a two-theatre twenty-bed PH facility is £21m-£25m. Smaller ten-bed PH facilities could be built for approximately £3-5m. These costs include capital expenditure, obtaining land and planning permission and meeting regulatory requirements.

²¹⁸ See paragraphs 3.22 and 3.23

- 8.7 It has also been suggested that partnering with an NHS PPU offers a low cost entry route into the PH market as this lowers capital requirements especially when it may involve running an existing PPU facility.²¹⁹
- 8.8 However, while these developments in the market may help to lower the capital costs of establishing some new PH facilities, these costs are not insignificant. Submissions suggest that the capital investment required to build a new PH facility can range from £3 million to upwards of £25 million (depending on the size of the PH facility and the range of treatments offered).

Recognition on PMI provider networks

- 8.9 To be financially viable in the long term, potential new-entrant PH providers need to secure income from a sufficient volume of patients to cover the cost of the investment required to enter the market and the ongoing cost of capital and equipment.
- 8.10 As noted in chapter 6, PMI funded patients account for 60 per cent of a PH provider's typical revenue stream on average.²²⁰ Furthermore, PH providers have stated that PMI funded patients are more profitable compared to NHS patients. This means that PMI revenue is crucial for the financial viability of a new entrant.
- 8.11 In order to receive revenue from a PMI provider, a PH facility needs to be included on that PMI provider's networks (see Box 8.1 below). The number of networks that a PH facility is included on determines the number of PMI funded patients that a PH facility is entitled to treat.

²¹⁹ PPU partnering is discussed in chapter 6 and in chapter 9.

²²⁰ See paragraph 6.43

Box 8.1: PMI Networks

PMI policies include a list, or network, of PH facilities which are available to a PMI policyholder. If a PMI policyholder is treated at a PH facility listed on the relevant network, it will be reimbursed by its PMI provider.²²¹

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

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

How network recognition is granted to PH facilities

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

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

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

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

²²¹ In certain circumstances a policyholder might elect to be treated at a PH facility that is not included on the relevant network where there is a medical reason why network PH facilities are not appropriate. In these circumstances the policyholder would be reimbursed. For this and other reasons, it is necessary for PMI providers to have relationships with PH facilities which are not included on their networks.

- 8.12 Since Bupa and AXA PPP together account for over 65 per cent of PMI funded patients, it is particularly important for a PH provider to be included on their networks - particularly those networks which generate the greatest patient volume and revenue. This is reflected in a number of submissions by PH providers and in the Laing & Buisson report which states that 'not being included on Bupa and/or AXA PPP networks could mean a significant shortfall in demand unless new PH facilities are strongly supported by self-pay patients or NHS commissioning'.²²²
- 8.13 Further, it may be important for new PH facilities to gain recognition from both Bupa and AXA PPP in order to attract consultants (and their PH patients) to the new PH facility. Evidence indicates that consultants want to treat patients at PH facilities that are recognised by all PMI providers as this gives them the widest possible pool of PH patient business. In particular, if a PH facility does not have recognition from both Bupa and AXA PPP, a consultant may decide to take their practice and patients to a PH facility that does, rather than split their work between two or more PH facilities. This is known as the 'consultant drag' effect – ensuring that all patients can be treated at the same PH facility.²²³

PMI network recognition as a barrier to entry

- 8.14 The OFT has received submissions from a number of PH providers which maintain that they are having difficulty establishing new PH facilities due to a lack of PMI provider network recognition.
- 8.15 One PMI provider submitted that it will not provide an absolute commitment to recognise a new PH facility before it has been built and any advance commitment would be contingent upon the PH facility

²²² Laing & Buisson, Laing's Healthcare Market Review 2010-11 pages 71-72.

²²³ This is supported by evidence from the OFT consultant survey which shows that approximately 40 per cent of consultants report that they only have admission rights to a single PH facility. Additionally, 52 per cent of consultants report that, in a typical month, they would only admit to or treat at a single PH facility. Of those consultants who indicated that they would usually treat patients at two different PH facilities, there was a strong tendency to treat most of their patients at their main PH facility - more than 60 per cent of consultants said that they would treat between 70 per cent and 100 per cent of patients there.

meeting certain requirements, including: (i) attracting a reasonable spread of consultants; and (ii) resulting in a better outcome for customers based on choice, quality and cost. Difficulties in obtaining such an advance commitment may deter new entry. In particular, smaller PH provider groups state that they are unwilling to risk the costs of setting up a new PH facility without an absolute assurance of PMI provider network recognition.

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

8.17 Exclusive PMI networks may not create barriers to entry if there is a prospect that competitive new entrants can still gain access to the network or supplant an existing PH facility. However, the OFT is concerned that existing larger PH providers with a degree of market power are able to use network negotiations to impose conditions that restrict new entry. In particular, the OFT has received evidence and allegations of the following practices imposed by the larger PH providers in relation to PMI network recognition:

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

These practices are reviewed below.

'One in all in' negotiations

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

- 8.19 As explained in chapter 6, in order to offer nationwide coverage, a PMI provider has to contract with the owners of solus or 'must have' PH facilities. The OFT has received evidence which suggests that the PH providers which own 'solus' and 'must have' PH facilities have often been able to ensure that all of their PH facilities are included on the standard hospital networks of the major PMI providers.
- 8.20 This 'one in all in' practice is also sometimes reflected in an express contractual provision to the effect that all PH facilities owned by the PH provider will have network recognition and all PH facilities subsequently acquired by the PH provider will automatically receive network recognition.
- 8.21 The OFT considers that the ability of PMI providers to exclude individual PH facilities from their networks, and supplant them with others or extend their network recognition, is critical for generating price and quality competition among PH providers. The 'one in all in' negotiating tactic restricts that ability by obliging PMI providers to include PH facilities on their networks at the possible expense of more efficient or competitive PH facilities that could better meet patient demand, possibly at a lower cost. This concern has also been expressed to the OFT by PMI providers and smaller PH providers.
- 8.22 The larger PH providers have argued that, although they do seek to include all of their PH facilities on a PMI provider's network when negotiating, they are not always successful in doing so due to the market power of the larger PMI providers. They cite the recent introduction by BUPA and AXA PPP of low cost networks earlier this year and one PMI provider's recent threat to delist an number of PH facilities owned by a PH provider from its standard network. The OFT is aware that this action is part of ongoing negotiations between the PH and PMI provider and it is not clear what the outcome of these negotiations will be.
- 8.23 Also, as noted in chapter 6, it is not apparent what impact the introduction of policies with 'low cost networks' will have on the PH market and the relationship between PH and PMI providers. It is too early to assess whether these networks will be sufficient to invite new entry.

Alleged pricing threats

- 8.24 As noted in Box 8.1, prices for specific procedures are negotiated at a national level by PMI providers, and cover all of a PH provider's PH facilities listed on the PMI provider's networks.
- 8.25 One PMI provider alleged that, in response to its plans to include a new PH facility on the network, a large PH provider threatened to increase its prices across all of its PH facilities in order to offset any potential loss of revenue it would suffer as a result of rival entry.
- 8.26 Some contracts between PH providers and PMI providers provided to the OFT impose a price clause which is triggered in circumstances where a competing PH facility has been recognised. In some cases, there is a formula for calculating a price increase and in others recognition of a rival PH facility will result in a price renegotiation between the PMI provider and the owner of the incumbent PH facility.
- 8.27 Some PH providers and PMI providers have also suggested that PH providers use the threat of potential price increases as a means of protecting their network position with PMI providers. In this context, the OFT has been presented with allegations that PMI providers have at times agreed not to recognise a competing PH facility in exchange for the incumbent PH provider not increasing prices across its network of PH facilities.
- 8.28 The OFT has also received submissions from some PH providers which suggest that in order to gain recognition on a PMI provider's networks, a new entrant would need to offer the PMI providers prices that are significantly lower than the larger PH providers in order to balance out any price increase that the PMI provider might suffer across the rest of the incumbent PH provider's portfolio of PH facilities as a result. Some PH providers also suggest that even offering lower prices has not secured recognition from PMI providers.
- 8.29 In addition, and separate to the pricing threats highlighted above, some contracts seen by the OFT between PH providers and PMI providers provide for retrospective rebates. A PMI provider will receive a rebate calculated according to the number of admissions or the percentage of a PMI provider's spend that is realised across the PH provider's network of PH facilities. It is possible that the imposition of loyalty rebates and

discounts by PH providers might add to incentives on a PMI provider not to recognise a new PH facility if doing so would reduce any rebate payable.

Other contractual provisions relating to entry

- 8.30 The OFT has received evidence that a number of PH providers have obtained an express contractual right of veto/sign-off from the PMI providers in circumstances where the PMI provider is considering adding a new PH facility to its network. Alternatively, some contracts impose a right for a PH provider to be consulted before any new network recognition is granted to a rival PH facility.
- 8.31 The OFT has considered whether the concerns identified above could be addressed through enforcement. In principle, some may fall within the scope of the Competition Act 1998. While the OFT would not rule out the possibility of such enforcement action should that be merited in the future, it considers that in the present circumstances enforcement action would not be appropriate to address these concerns. Enforcement would have been limited in scope to particular instances of anti-competitive behaviour in particular local areas. Enforcement action would not address the underlying features identified and set a sufficient and clear precedent. These reasons are examined in more detail in chapter 10.

Assessment of harm

- 8.32 The OFT considers that the above alleged practices are capable of creating significant barriers to entry, and thereby restricting competition in the PH market. The ability of PMI providers to include new PH facilities on their networks (whether at the expense of or in addition to incumbent PH facilities) is critical for generating price and quality competition, and for driving efficiency and innovation in PH provision. Restrictions on PMI providers' ability to recognise competing PH providers are therefore likely to have a significant impact on competition in the PH market.
- 8.33 PH providers submit that if one PH facility is removed from a PMI provider's network or its patient volume drops as a result of recognition of a rival PH facility, it is reasonable to increase prices across its PH facilities due to the increased cost, on average, of treating fewer

patients. In some cases PH providers consider that recognition of a new PH facility might result in both PH facilities operating significantly under capacity, thereby requiring offsetting price increases across the PH provider's portfolio of PH facilities.

- 8.34 PH providers also argue that only by ensuring that all of their PH facilities are recognised can they realise economies of scale across their network, and spread the costs of innovation and cutting edge equipment across PH facilities.
- 8.35 The OFT acknowledges that there may be some efficiency benefits in limiting new entry where existing PH facilities have strong economies of scale and scope. However, as noted in paragraph 8.5, a number of innovations in healthcare, coupled with a preference for outpatient and day-case care seem to be reducing the fixed costs of entry and limiting the economies of scale in PH provision, resulting in smaller clinics. These developments appear to reduce the justification of efficiency benefits that may result from limiting new entry and make it important to encourage new entry and innovation.
- 8.36 Moreover, as noted in chapter 5, patients are currently not in a position to drive competition given the shortage of comparable quality information on PH facilities in the market, and the absence of price sensitivity among PMI funded patients. The OFT considers that this makes it all the more important that the ability of PMI providers to drive competition between PH providers through network recognition is unencumbered.

Consultant incentives

- 8.37 This section considers how the need to attract consultants to treat patients at a new PH facility may constitute a barrier to entry. It further sets out how incumbent PH providers appear to offer consultants incentives (or conversely disincentives - in the form of proposed or actual withdrawal of practising privileges) which could serve to raise barriers to new PH provider entrants.

The importance of consultants to PH providers

- 8.38 Consultants are very important to PH providers given that patients are usually referred by their GPs to a consultant rather than a PH facility.

Evidence also indicates that a patient is unlikely to change consultant in order to get a different choice of PH facility.²²⁴ It is therefore mainly consultants who bring patients into a PH facility and generate revenue for it.

- 8.39 As noted in paragraph 3.19 above, consultants usually choose to focus their work at one main PH facility. Competition to be a consultant's main PH facility is high because consultants are able to 'drag' patients towards PH facilities since some consultants seem reluctant to split their practices across PH facilities (as explained in paragraph 8.13 above).
- 8.40 Therefore, it is important for PH facilities to attract and retain consultants and this appears to be a key dimension of competition between PH providers at the local level.
- 8.41 The OFT has received evidence that the two most important factors influencing a consultant's choice of PH facility are quality and convenience.
- 8.42 In relation to convenience, the OFT's consultant survey showed that 96 per cent of private consultants hold an NHS post and only attend to their private practice outside of their NHS contracted hours. Therefore consultants tend to choose a PH facility that is close to the NHS facility where they practice.²²⁵ The location of a PH facility may therefore be an important element of competition between PH providers at a local level.
- 8.43 The OFT consultant survey also showed that one of the reasons why a consultant chooses one PH facility over another is how the PH facility manages the administrative burdens faced by consultants.²²⁶ Administrative support, such as a streamlined billing process or secretarial support, is an important aspect of a PH facility's offering to consultants, and PH providers can offer specific administrative incentives to attract consultants (see below).

²²⁴ As explained in paragraphs 3.17 to 3.19

²²⁵ The OFT consultant survey shows that for 85 per cent of consultants surveyed the travel time between their main PH facility and their main NHS facility was between 0 and 30 minutes.

²²⁶ OFT consultant survey, page 65

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

Types of consultant incentives

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

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

to direct financial incentives, such as:

- bonus payments contingent upon a volume target being met
- annual bonus payments calculated as a percentage of the revenue that the consultant generates for the hospital group in question
- loyalty payments which reward consultants for treating a higher proportion of their patients at a facility
- an equity stake in the PH facility, offering consultants a share in the profit of the PH facility in exchange for a commitment to treat a certain percentage of their patients at the PH facility.

8.46 Indirect incentives are widespread in the market.²²⁷ All PH providers that submitted evidence to the OFT offer some form of non-financial incentives to their consultants.

8.47 A small number of PH providers indicated that they offered direct financial incentives to attract consultants,²²⁸ while a number of other

²²⁷ The OFT consultant survey, at pages 65-6, shows that consulting room prices can be an influential factor for why a consultant may switch (or consider switching) between main PH facilities

²²⁸ The OFT consultant survey shows that consultants typically had not entered into any agreements with the PH facilities at which they possessed admission rights (85 per cent). The

stakeholders suggested that direct financial incentives are available to consultants, particularly in London.

- 8.48 In addition, the OFT has received copies of contracts between some PH providers and consultants which contain clauses which make the availability of incentives (whether direct or indirect) subject to a requirement on the consultant not to treat patients at a competing PH facility or subject to the consultant not obtaining an equity interest in a competing PH facility. Certain submissions also allege that the possibility of new entry results in some PH providers proposing to withdraw consultants' practising privileges (and in some cases actively withdrawing practising privileges) if they treat patients at the new, competing, PH facility.
- 8.49 The availability of volume based bonuses or payments from one PH facility might also have the effect of an exclusivity provision given that consultants often prefer not to split their patient lists between two PH facilities.²²⁹ Thus, although a consultant might be contractually free to treat patients at another PH facility, he or she may be disincentivised to do so in circumstances where this would result in foregoing a loyalty payment.

Consultant incentives as a barrier to entry

- 8.50 If a new PH facility is unable to attract consultants in a local market, whether as a result of exclusivity provisions or from a consultant's desire not to forego bonus payments from the incumbent PH facility, then where the incumbent has market power the new PH facility may have difficulty entering the local market.
- 8.51 Several PH providers have provided evidence that they will not open a PH facility or expand an existing PH facility without first obtaining commitments from consultants that they will treat patients at that PH facility. Indeed, as noted in paragraph 8.15 above, PMI providers can

remaining consultants had entered into agreements of varying types with no more than one or two per cent of respondents in each case highlighting a specific form of agreement, indicating that they were very uncommon.

²²⁹ As explained in detail in chapter 5.

make it a condition of an advance commitment to recognise a new PH facility that the new facility has attracted a reasonable range of consultants. If an incumbent PH provider is able to tie up the available consultants, new entry will be more difficult.

- 8.52 In principle, an efficient new PH facility could offer similar or better incentives to attract consultants away from incumbent local PH facilities. However, as noted in paragraph 8.39 above, many consultants are unwilling to split their private treatment lists between two or more PH facilities (the consultant drag effect). If the incumbent PH provider enjoys local market power and thereby already accounts for a high proportion of consultants' PH treatments, loyalty payments or exclusivity provisions imposed by the incumbent PH provider are likely to exacerbate this drag effect, by further incentivising consultants to treat all their private patients at the incumbent PH facility. In this way, new entrants may have difficulty attracting consultants even with similar incentive schemes.
- 8.53 The OFT therefore considers that where consultant exclusivity or loyalty is encouraged or required by PH providers with local market power using direct or indirect financial incentives this may create further barriers to entry in the PH market.
- 8.54 Other types of consultant incentives, which encourage PH facilities to compete for consultants on the basis of superior quality of PH facilities, better care and services, or administrative support are unlikely to present competition concerns. This type of competition for consultants is likely to encourage PH providers to innovate in the way that they offer care and as a result may generate longer term benefits for patients.

GP incentives

- 8.55 The OFT has received limited evidence of some PH providers with local market power also potentially seeking to tie in GPs by means of referral incentives and requirements. In particular, the OFT has been presented with copies of contracts between PH providers and GP surgeries under which the PH provider acts as landlord to a GP surgery and appears to incentivise the GP surgery to make referrals to that PH provider by offering discounted rent in exchange for patient referrals. The OFT has also received evidence of a scheme under which a PH facility pays GP

surgeries for carrying out pre-operative assessments on patients provided that the patient is subsequently treated at one of the PH provider's facilities.

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

Provisional findings: barriers to entry and expansion

- 8.57 For the reasons analysed above, the OFT considers that a number of features of the PH market combine to create significant barriers to entry. These are:

- certain conditions imposed by larger PH providers as part of the recognition of their facilities on PMI networks which may restrict the ability of PMI providers to recognise new entrants attempting to offer competing PH services on their networks. For example, some PH providers impose conditions on PMI providers that they be consulted on the recognition of a new entrant on a PMI providers' network, or that impose price rises on a PMI provider should a new entrant be recognised
- the practice of many consultants is to treat most of their private patients at one main PH facility. Since patients are insured by different PMI providers, this practice means that new entrants, attempting to offer competing PH services, need to be recognised on all of the main PMI networks in order to attract a sufficient number of consultants to practice at their facility (the 'consultant drag' effect.)
- incentives paid directly or indirectly by PH facilities to consultants to encourage them to treat all, or a higher number, of their patients at their facility. These incentives may further discourage consultants from treating patients at the facilities of new entrants, attempting to offer competing PH services

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

8.58 The OFT notes that many of these features are intrinsically linked to the other aspects of this market examined in chapters 5 and 6. In particular, the ability of larger PH providers to impose conditions on PMI providers regarding network recognition seems to derive from their local market power discussed in chapter 6. In addition, the shortage of comparable quality information on PH facilities, examined in chapter 5, may make it harder for new PH provider entrants to establish a reputation for quality in the market by which to attract consultants and patients away from incumbent PH providers.

9 OTHER STUDY FINDINGS

PMI provider transparency

- 9.1 As set out in chapter 5 the OFT has found evidence of variable practice as to how and when consultants communicate prices to PMI funded patients.²³⁰
- 9.2 In most instances, the lack of discussion on fees prior to treatment does not give rise to any difficulty for the patient, as this fee will fall within the PMI providers' fee schedules and the PMI provider will pay for all the treatment. However some consultants charge fees in excess of a PMI provider fee schedule, leaving the PMI funded patient in a position where they may have to pay an unexpected shortfall to the consultant.
- 9.3 As set out in chapter 7 above, the evidence received from the market study shows that anaesthetists are the most likely group of consultants to shortfall patients. Anaesthetists are also the group most likely to have no contact with patients prior to the operating theatre,²³¹ and formation of AGs may reduce price competition in certain local markets.
- 9.4 As a result of concerns expressed by consumers in relation to extra payments sought by some medical practitioners when costs are not completely covered under PMI policies, the OFT has raised this issue with the Financial Services Authority during the course of this market study. As a result, the FSA has determined to work with the Association of British Insurers (ABI) and individual PMI providers to ensure that they make clear the possibility of a shortfall due to limits which apply to the amount payable under their policies, both at the point of sale and at the time a consumer makes a claim under the PMI policy. Such disclosure is in fact already required under existing FSA rules.²³²

²³⁰ See paragraph 5.45

²³¹ See paragraph 5.47

²³² FSA Product Information rules require firms to take reasonable steps to ensure a customer is given appropriate information about a policy in good time and in a comprehensible form so that the customer can make an informed decision about the arrangements proposed. This information includes policy terms, including the main benefits, exclusions, limitations, conditions, and duration (Insurance: Conduct of Business sourcebook (ICOBS) 6.1.5R and 6.1.7G). Under the

PPU partnering

- 9.5 As set out in chapter 6 above, the evidence gathered during the study highlights an increasing trend for PPUs to 'partner' with PH providers. This may not in itself cause concern unless the arrangement is likely to increase concentration which may lead to an increase in market power and a reduction in competition. The OFT proposes to ask the CC to consider this issue further as part of the proposed market investigation reference.
- 9.6 Certain PPU partnering arrangements may qualify for review under the merger provisions set out in Part 3 of the Enterprise Act 2002, depending on the nature of the arrangements in each case.²³³ In this context, the OFT recommends that parties entering into PPU partnering arrangements assess whether the arrangement may qualify for merger review. Given the UK's 'voluntary' merger regime, there is no requirement to notify mergers to the OFT, and parties are able to decide themselves whether they wish to proceed with a transaction without first obtaining regulatory approval.
- 9.7 However, the OFT can make inquiries of its own initiative where it believes that it may have jurisdiction and it has a dedicated Mergers Intelligence Officer responsible for monitoring non-notified merger activity. The OFT is able to call such non-notified cases in for a review at any point up to four months after the merger has completed (or was 'made public', if that occurs later). As a result, parties should be aware that proceeding with a transaction that may qualify for merger review and raise competition concerns does carry certain risk: see paragraphs 4.21 to 4.24 of the OFT's *Mergers – Jurisdictional and procedural*

FSA's Claims Handling rules, insurers are required to handle claims promptly and fairly, and to provide reasonable guidance to help a policyholder make a claim and appropriate information on its progress (ICOBS 8.1.1). In accordance with the memorandum of understanding between the OFT and the FSA, both parties will continue to work together to protect consumers interest, www.fsa.gov.uk/pubs/mou/fsa_ofi.pdf

²³³ The Enterprise Act merger provisions apply to 'relevant merger situations', which occur when two or more 'enterprises' 'cease to be distinct' and the transaction or arrangement meets either a turnover test or share of supply test. For guidance on what the OFT will consider to be a relevant merger situation see OFT527, *Mergers – Jurisdictional and Procedural Guidance*, Chapter 3.

guidance.²³⁴ Parties to a merger and their advisers may approach the OFT for informal advice about the OFT's views of jurisdictional and competition issues in a future transaction. Pre-notification discussions are also available where the parties wish to proceed to notify a merger.²³⁵

Competitive neutrality

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

²³⁴ OFT527, Mergers – Jurisdictional and Procedural Guidance.

²³⁵ For further information on the availability of informal advice and pre-notification discussions see OFT527, Mergers – Jurisdictional and procedural Guidance, Chapter 4.

A market-consistent ROR would be one that is comparable with what is earned by the majority of firms within the same industry.²³⁶

²³⁶ Further information can be found in OFT working paper, *Competition in Mixed Markets: ensuring competitive neutrality*, OFT 1242.

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

- 10.1 The OFT has reasonable grounds for suspecting that there are features of the PH market, which, individually or in combination, prevent, restrict or distort competition in connection with the supply or acquisition of PH services in the United Kingdom.
- 10.2 Section 131(2) of the Enterprise Act 2002 states that a feature of a market is to be construed as a reference to:
- the structure of the market concerned or any aspect of that structure
 - any conduct (whether or not in the market concerned) of one or more than one person who supplies or acquires goods or services in the market concerned or
 - any conduct relating to the market concerned of customers of any person who supplies or acquires goods or services.²³⁷
- 10.3 The features identified by the OFT are the following:
- 10.4 **Information asymmetries:** As analysed in chapter 5, the OFT considers that there is a shortage of accessible, standardised and comparable information provided to patients, GPs and PMI providers in relation to the quality of PH facilities and of consultants. There also appear to be difficulties for PMI funded patients in assessing the risk of shortfall from particular consultants, whereby a consultant's fees exceed the benefit maxima that the patient's PMI provider will reimburse resulting in the potential for an additional payment by the patient. In addition, for self-pay patients, there are difficulties in easily comparing the prices charged by different PH facilities.
- 10.5 In general, the OFT considers that this shortage of accessible, standardised and comparable information weakens the ability of patients and GPs to drive efficiencies and stimulate enhanced competition

²³⁷ Section 131(3) of the Enterprise Act 2002 notes that conduct includes any failure to act and any unintentional conduct.

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

- 10.6 Finally, the OFT notes that information asymmetries are a factor across a number of other problems examined in this report, including the limits on the ability of PMI providers to exercise buyer power which is examined in chapter 6. The lack of access to comparable quality information on PH facilities may also facilitate a competitive dynamic whereby competition between PH providers is based less on the quality of services provided to patients and, since a consultant often chooses at which PH facility the patient is treated, more on attracting consultants to their PH facilities through the use of a variety of contractual and non-contractual incentives. This may increase the cost of PH without necessarily driving improvements in the quality of services provided to patients. The development of consultant incentives is examined in chapter 8.
- 10.7 **Concentration.** As examined in chapter 6, the PH provider market appears to be concentrated at the national level. At the local level there appear to be areas of high concentration, such as areas where there is no alternative fascia PH facility within a 30 minute drivetime of a PH facility (solus PH facilities), and some local markets with 'must have' PH facilities.
- 10.8 The existence of solus and 'must have' PH facilities means that PMI providers are dependent on the PH providers that own these facilities in order to provide nationwide coverage for their policyholders.
- 10.9 The size of the larger PMI providers appears to result in a degree of buyer power in that PH providers are, to some extent, dependent on these larger PMI providers for the financial viability of their facilities. However, there may be limits on the PMI providers' ability to exercise

their buyer power. Firstly, in order to provide nationwide coverage, PMI providers need to purchase PH in most local markets, including areas with solus and 'must have' PH facilities as described above. Ownership of these facilities appears to give PH providers bargaining leverage over PMI providers. Secondly, since it is GPs that usually recommend consultants to patients, and consultants who then often determine the patient's choice of PH facility, the PMI providers have limited ability currently to direct patients to different PH facilities. Therefore, as the buyer power of the PMI providers appears not to be countervailing, the larger PH providers may have a degree of market power.

- 10.10 The OFT notes that the development of partnership arrangements between PPUs of NHS/Foundation Trusts and PH providers has the potential to either exacerbate or alleviate concentration in local PH markets. Local market concentration may increase if a PH provider that is already present in the local market partners with the PPU. This is because the partnering arrangement may remove any competitive constraint on the relevant PH provider offered prior to the partnering arrangement and reduce choice for PH patients and PMI providers. On the other hand, a partnership arrangement between a PPU and a new PH provider in the local market has the potential to provide a platform for entry and thereby to increase competition. As a result of this market study, the OFT has made a recommendation to the Department of Health and to the NHS/Foundation Trusts in relation PPU partnering arrangements (see chapter 9).
- 10.11 As examined in chapter 7, forty-four per cent of anaesthetists are part of an Anaesthetist Group (AG). Prior to, and during the course of, the market study, the OFT received a number of complaints from patients regarding their inability to find an anaesthetist who will charge within PMI provider fee schedules. These complaints have been supported by submissions and evidence from PMI providers as part of the market study that high concentration of AGs in some local markets may raise prices. In the light of these complaints, the OFT suspects that the prevalence of AG groups is also a feature of the market which may reduce price competition in local markets (particularly in view of switching costs such as the costs associated with postponing treatment or travelling to an alternative facility).

10.12 **Barriers to entry.** For the reasons analysed in chapter 8, the OFT considers that a number of features of the PH market combine to create significant barriers to entry. These are:

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

10.13 The OFT notes that many of these features are intrinsically linked to the other aspects of this market examined in chapters 5 and 6. In particular, the ability of larger PH providers to impose conditions on PMI providers regarding network recognition seems to derive from their local market power discussed in chapter 6. In addition, the shortage of comparable quality information on PH facilities, examined in chapter 5, may make it harder for new PH provider entrants to establish a reputation for quality

in the market by which to attract consultants and patients away from incumbent PH providers.

10.14 It is the OFT's provisional view that the Section 131 test for making a reference is met and, therefore, the decision on whether to make a reference rests on the exercise of the OFT's discretion.

Appropriateness of a reference

10.15 The OFT's guidance on market investigation references²³⁸ sets out four criteria, all of which must be met before the OFT will exercise its discretion to make a reference to the CC.

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

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

Alternative powers

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

²³⁸ *Market Investigation References – Guidance about the making of references under Part 4 of the Enterprise Act*, March 2006.

- 10.18 The OFT has conducted an analysis, based on the information received in this market study, as to whether the barriers to entry identified in chapter 8 that result from PMI network recognition, or from certain consultant financial incentives offered by PH providers may be addressed more appropriately through CA98 enforcement action. While the OFT would not rule out the possibility of such enforcement action should that be merited in the future, it considers that in the present circumstances enforcement action would not be appropriate to address these barriers to entry for two reasons. First, the OFT considers that these barriers to entry are intrinsically linked to the broader, complex and inter-related set of issues addressed in this report, and would need to be addressed as part of a holistic examination of the market. Second, the OFT is concerned that enforcement action against a limited number of practices, were that possible, may not establish a sufficient precedent by which to deter other, similar types of practice. These reasons are examined in more detail below.
- 10.19 Although the OFT notes that there may be individual agreements and/or practices in place in the PH market which could potentially be addressed by investigation and possible enforcement action under Chapter I/Article 101 or Chapter II/Article 102, such enforcement action (insofar as merited) would not address the significant inter-connected structural aspects of this market that underlie the barriers to entry identified in this market study. In particular, the OFT has noted in this market study that the ability of PH providers to impose these barriers to entry derives from the information asymmetries and concentration features of the market examined in chapters 5, 6 and 8. As analysed in chapters 6 and 8, the ability of larger PH providers to impose conditions on PMI providers regarding network recognition seems to derive in large part from the local market power derived from ownership of solus or 'must have' PH facilities. In addition, as examined in chapter 5, the lack of access to comparable quality information on PH facilities helps to create a competitive dynamic where competition between PH providers is based less on quality of the services provided to patients, and based more on attracting consultants to their facilities through the use of a variety of contractual and non-contractual incentives. The OFT considers that these complex and inter-connected features are more appropriately

addressed by means of a holistic examination of the market and also an examination with the potential for market-wide remedies.²³⁹

- 10.20 Furthermore, an important factor in assessing whether enforcement action is appropriate is whether that action would set a sufficient and clear precedent, thereby creating certainty among industry participants and deterring similar agreements or behaviour in the future. However, as set out in chapter 8, the practices in relation to PMI network recognition, or consultant financial incentives are potentially fact and/or locality specific and therefore quite varied in nature. In this context, the OFT considers that any enforcement action, if merited, against a limited number of practices may not be sufficiently similar to other market practices to either establish a precedent to provide clarity to market participants or to deter other variant practices .
- 10.21 The OFT has also considered whether the issues it has identified could be more appropriately addressed through recommendations to Government Departments, health regulators or other sectoral bodies.
- 10.22 In relation to the features of concentration and barriers to entry, the OFT considers that it would not be possible to address the concerns identified through recommendations to Government Departments, health regulators or other sectoral bodies. In relation to the feature of information asymmetries, while the OFT welcomes the willingness among some industry participants to improve the availability of accessible, comparable information on quality, the OFT does not consider that there is sufficient consensus among all the necessary sectoral bodies and industry participants such that its concerns could be addressed through voluntary recommendations within a sufficient timescale. Although the CQC has a role in regulating PH providers and imposing conditions of registration, it has confirmed that it does not have the power to mandate the types of measures set out in section 10.27 below on possible remedies.

²³⁹ As set out in the OFT MIR Guidance (paragraph 2.14), as a result of the application of Council Regulation No.1/2003, the CC would be unable to impose remedies addressing such agreements without parallel proceedings being opened under Article 101 (it would, however, be able to continue its investigation until the stage at which remedies are imposed). In these circumstances, it may remit such agreements to the OFT for further consideration under Article 101. The OFT has taken this possibility into account when proposing to make this reference.

10.23 This report does make three specific recommendations to address particular issues that arose in the course of the market study. We do not propose these as solutions to the features identified above. However, the OFT would welcome any additional immediate engagement with stakeholders by which we could have further impact even before any definitive view is reached on an MIR.

Scale of the problem

10.24 The OFT considers that a reference would be an appropriate response in this market given both the scale and the complexity of the suspected problems identified. This view is reached for two reasons.

10.25 First, the size of the market is significant and estimated to be approximately £4.94 billion. There is also scope for this market to grow in the future in line with an ageing UK population and a consequent growth in the demand for healthcare provision.

10.26 Second, a significant proportion of the market is affected by the features that prevent, restrict or distort competition, which appear to apply to most of the UK. The features identified above are inter-related and the consumer harm they generate affects all PH patients to some extent. In particular, the combination of information asymmetries, high concentration and barriers to entry in the PH market results in reduced choice for patients. It also restricts competition between PH providers and between consultants by impairing the ability of patients, GPs and PMI providers to choose between competing service providers, including new entrants, on the basis of superior quality and better value for money. This might be expected to result in higher prices and lower quality of services for patients and innovation in the PH market.

10.27 Finally, the features identified as adversely affecting competition are unlikely to be short-lived. In this context, it is worth noting that potential issues relating to information asymmetry, concentration and barriers to entry in the market for PH in the UK have been noted in previous market and merger analyses of the OFT and CC dating back to 1994, although in the context of these studies it was not necessary to reach definitive conclusions on these issues.

Availability of remedies

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

- in respect to consultants, the formulation and publication of outcome and process measures relating to treatments conducted by individual consultants – especially for routine, elective treatments – made directly available to patients GPs, PMI providers, PH providers and other relevant bodies (for example, Dr Foster) which can then be interpreted and conveyed to patients indirectly ²⁴⁰
- the development of a choice-tool ²⁴¹ for private patients by which self-pay prices could be better compared between rival facilities (and perhaps contrasted with PMI premium prices also)
- obligations on consultants to provide a fee estimate at or soon after first consultation in order to show an indicative price for treatment. ²⁴²
- as part of a fee estimate, consultants could provide information to patients on how many times in a specified time period they had requested a shortfall payment from a patient funded by PMI (across all PMI providers)
- consultants could make their charges for a first consultation with a private patient more widely available so that patients are able to compare fees prior to attending a consultation

10.31 Concentration of PH provision. Potential remedies in this area could include:

²⁴⁰ Requiring the provision of NHS outcomes data may require the CC making recommendation to Government

²⁴¹ For further discussion on choice-tools, see: Office of Fair Trading, *Empowering consumers of public services through choice-tools*, April 2011 (OFT1321), p12 in particular

²⁴² CQC is a regulator of quality and safety under the Health and Social Care Act 2008, it has confirmed that Regulation 19 of the CQC regulations relating to fees provides for a 'statement' which must be in writing and as far as possible, is provided before the services are provided. However, CQC cannot mandate that the information is always provided before the service is received, although it suggests it should only be exceptional where it is not.

- a recommendation to NHS Trusts/ Department of Health that PPU partnership arrangements should not be undertaken with a PH provider that has more than a certain share of the local market, or be subject to establishing certain conditions of access
- obligations on PH providers in relation to access to their solus or 'must have' facilities.

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

- a ban on provisions in contracts between PH providers and PMI providers that concern the recognition of new, rival facilities on the network of the PMI provider
- a ban on PH providers with local market power operating consultant incentive schemes that may disadvantage new entrants or smaller providers seeking to enter the market
- the introduction of transparency requirements for consultants such that they are required to provide details of any incentives that they receive from a PH provider to their patients, GPs and PMI providers.

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

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

Undertakings in lieu of a reference

10.35 The OFT has power under Section 154 of the Enterprise Act 2002 to accept undertakings in lieu of a reference to the CC.

10.36 As noted in paragraph 10.29 above, the OFT has invested considerable thought and effort during the course of the market study in order to see whether the market features it has identified could be resolved by the OFT through actions agreed with industry participants. To date, the OFT's efforts have not led to consensus on the appropriate course of

action within the timescale of the market study. Therefore, the OFT considers that specific undertakings or orders, of the type the CC is able to agree or make, would be necessary to address the problems it has identified.

10.37 However, undertakings in lieu of a reference could provide a tool for addressing the market features identified through binding undertakings or commitments by industry participants along the lines of the potential remedies described above. In this context, the OFT will consider any proposals for undertakings in lieu of a reference made during the course of this consultation. However, the OFT is concerned that, given the complex and inter-related nature of the issues, and given the diversity of views expressed by industry participants in the course of the market study on possible solutions, it may not be possible to agree undertakings in lieu of a reference.

Conclusion

10.38 In conclusion, the OFT provisionally considers that the test in Section 131 of the Enterprise Act 2002 is met, that is there are reasonable grounds to suspect that there are features of the market for PH which prevent, restrict or distort competition.

10.39 The OFT has identified features of the market as information asymmetries, concentration and barriers to entry. It is the OFT's provisional view that these features, either individually or in combination, restrict, prevent or distort competition.

10.40 For these reasons described in paragraphs 10.4 to 10.14, above the OFT has provisionally decided to exercise its discretion to refer this market to the CC.

A TERMS OF REFERENCE

- A.1 The OFT, in exercise of its powers under Sections 131 and 133 of the Enterprise Act 2002 (the Act), hereby makes a reference to the CC for an investigation into the supply or acquisition of PH in the UK.
- A.2 The OFT has reasonable grounds for suspecting that a feature or a combination of features of the market or markets for the supply or acquisition of PH prevents, restricts or distorts competition.
- A.3 For the purposes of this reference, PH means privately funded healthcare services. These include 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.

B OFT ROUNDTABLES

Overview

- B.1 On the 6 and 9 September, the OFT held two roundtables with 32 interested parties regarding the OFT's concerns that there appeared to be a lack of comparable information on the quality and price of PH facilities and consultants. A complete list of participant organisations is provided below.
- B.2 Both roundtable meetings were preceded by an Issues Paper setting out the OFT's early provisional findings in regard to quality and price information for both PH facilities and consultants. The Issues Paper outlined some initial, formative concerns in regard to information asymmetries which, following further analysis and additional consideration subsequent to the roundtables, are now described at (please see 5.12 of the main report). In order to shape the roundtable discussion and elicit debate, the OFT also set out some possible measures to address the concerns outlined. These possible measures, and the views expressed by participants on them, are set out in this annex.
- B.3 The OFT derived a substantial amount of benefit from the roundtable discussions, and would like to thank all participants for their contribution.

Summary of roundtable discussion

- B.4 Although there was a good deal of consensus amongst participants across both roundtables about the benefit of greater information for patients and GPs, there was a clear diversity of views between participants in regard to how greater comparable information on quality could be developed and on how fee visibility could be improved.
- B.5 Overall, the diversity of views between market participants attending the roundtable suggested to the OFT that, as also set out at paragraph 10.29, voluntary recommendations to address its concerns regarding information asymmetries would be insufficient given the lack of consensus required to take any non-binding recommendations forward.

Views on potential measures

PH Facility Information

B.6 The OFT set out four possible measures relating to quality information for PH facilities in order to elicit discussion amongst roundtable participants. These were:

- **Measure 1:** PH providers, building on Hellenic Project work, to publish comparable quality information to an equal or greater extent to that found for NHS facilities. This would enable greater integration of PH facilities into NHS Choices website and other uses (for example, Dr Foster report cards)
- **Measure 2:** PH providers to agree and select a smaller set of standardised measures (ranging across the three domains of quality and comparable to NHS measures) for external publishing available directly to private patients, as well as GPs, PMIs and regulators
- **Measure 3:** PH providers agree on standardised methodology for producing patient experience information to aid comparability
- **Measure 6:** Recommend the development of a choice-tool²⁴³ for private patients by which self pay prices could be better compared between rival facilities (and perhaps contrasted with PMI premium prices also)

Discussion Summary

B.7 **Hellenic Project:** Participants to the roundtable were provided with an update on the Hellenic Project's progress to date with particular focus on the complexity of the work being undertaken in order to explain perceived delays in its progress. Following this update, a number of topics connected to the project were discussed:

- **Comparability with NHS:** A large part of the discussion concentrated

²⁴³ For further discussion on choice-tools, see: Office of Fair Trading, *Empowering consumers of public services through choice-tools*, April 2011 (OFT1321), p12 in particular

on how the Hellenic Project would compare to what has already been achieved in the NHS in terms of data comparability (resulting in NHS Choices for instance). Some participants were keen to emphasise that the distinction between a 'NHS patient' and a 'private patient' was an increasingly academic one with patients often switching between public and private providers. As a result, some participants believed that any changes which maintained this distinction, or risked frustrating the ability of patients to compare PH facilities between sectors, would not be sufficient in addressing present information asymmetries. This contrast in opinion served to crystallise views in regard to measure 1 and 2, and provided the basis on which many of the topics listed below were discussed:

- **Mirroring or adoption:** Some participants advocated that, instead of the creation of a bespoke PH system mirroring Hospital Episode Statistic (HES) fields,²⁴⁴ the project should instead concentrate on the wholesale adoption of HES so that both NHS funded (as present) and privately funded patient episodes would be submitted to the HES system to aid comparability. Other participants stressed how difficult this would be to achieve given different coding formats for private patient treatment episodes,²⁴⁵ and in any case believed that PH providers should retain control of this data in order to further innovate away from the public sector's system (which, it was suggested, could be improved upon). Other participants advised that it was due to limitations in current coding for private patient episodes that HES should be wholly adopted (including its coding formats) as the level of

²⁴⁴ HES, as outlined in paragraph 5.19 of the main report, represent an administrative database which detail treatment episodes of all NHS patients in England and provides the basis for many comparable measures available on NHS facilities

²⁴⁵ At the current time, the procedures carried out on privately funded patients are defined via CCSD codes (named after the Clinical Coding & Schedule Development Group made up of the five major PMI providers). These codes (their use necessary for billing the PMI providers) differ from the OPCS-4 coding system used in HES for the NHS (OPCS-4 standing for: Office of Population, Censuses and Surveys: Classification of Interventions and Procedures, 4th Revision). Also relevant here is that private patient treatment episodes may not be ICD-10 coded. The lack of ICD coding (which records diagnosis and other conditions) makes risk adjustment for co-morbidities difficult.

comparability offered by the Hellenic Project was insufficient.

- **Two websites:** A possible product of the Hellenic Project would be the creation of a bespoke, PH website where comparable quality data for the PH facilities could be displayed to patients. Some participants worried that this would create confusion as the same PH facility may be listed under both this new PH website and the NHS Choices website, but show different values for the data being compared (as they would be based on different datasets).
- **Recording entire patient episodes:** Some participants were concerned that, should a patient's treatment episode span both private and public sectors (such as a readmission to an NHS facility after complications) these incidences would not be recorded sufficiently; instead they may fall between datasets.
- **Linked data:** Concerns were raised by some participants in regard to whether the Hellenic Project's dataset, whilst more comparable, would be linked to other datasets (ONS, PROMs,²⁴⁶ clinical audits) to the same degree that HES allows.
- **Patient Experience Methodology:** In relation to measure 3, there was confirmation at the roundtable that the Hellenic Project would involve the setting of a common methodology for formulating a selection of inpatient patient experience questions.
- **Smaller PH providers:** Whilst the Hellenic Project's participants represented the overwhelming majority of PH providers (including all major providers), some participants wondered whether participation in the project – and the collection and submission of data – should be made mandatory for a PH provider to ensure full comparability across the industry.

²⁴⁶ Patient Reported Outcome Measures (PROMS) represent a set of outcomes data for an initial group of four elective treatments commonly undertaken in private healthcare (knee and hip replacements, groin hernia surgery and varicose vein surgery). Via the use of pre and post treatment surveys, PROMs allows an average health gain measure to be produced for the purposes of improving performance and public information. Outcomes data from PROMs is also currently found on NHS Choices.

- **Release of data and relations with public sector:** Some participants said that the public sector could be more forthcoming in engaging with the Hellenic Project and the independent sector in general in order to support the provision of better comparable data for PH facilities. In particular, the release of certain data held by public sector bodies (specifically infection control data from the Health Protection Agency and PROMs data from the Department of Health) in order to further aid the development of comparable measures in the PH sector.

B.8 Consultant information more important for choice: Some participants felt that patients' choices on PH facilities tended not to be dependent on the quality of the PH facility, but rather they focused on the geographical location. As a result, these participants thought that data relating to PH facility quality was more about providing the patient with **reassurance** rather than supporting the active making of an informed choice.

B.9 In turn, some participants stressed that most referrals by GPs were to named consultants and therefore it was consultant quality information which was more important in terms of supporting active, informed choices for the patient and, consequently, driving demand-side competition in the market for acute private healthcare.

B.10 Infection Data: Some participants noted how PH providers had been voluntarily providing the Health Protection Agency with data on HAIs (Hospital Acquired Infections). This has now resulted in the HPA issuing a report containing this data.²⁴⁷

B.11 Quality Information given to PMI providers: Some participants said that PMI providers could do more to support comparable information between PH facilities, especially if, as part of recognition criteria, the PMI provider receives extra clinical information in regard to the work of the PH facility. These participants questioned whether enough was done to

²⁴⁷ The OFT notes a discrepancy between the volunteering of infection data by PH providers and its lack of representation on NHS Choices as provided by the HPA. This is due to NHS Choices using a dataset from the HPA pertaining only to NHS facilities. The HPA has published a report outlining some of the difficulties involved in comparing infection data between PH facilities available at: www.hpa.org.uk/webc/HPAwebFile/HPAweb_C/1284474832121 (last accessed 12 December 2012)

convey this information to PMI policyholders.

- B.12 **Clarity of PMI policies:** Some participants questioned the degree to which PMI policies were understandable, transparent and clear on what they excluded at when the policyholder bought the policy (that is, the point of sale as opposed to referral).
- B.13 **Self-Pay:** There was some discussion of self-pay prices. Overall, there was some difference expressed over how transparent prices were. Some participants advocated the need for a standardised, itemised hospital cost bill which would ensure inclusion of more ancillary costs (such as prosthesis). However, some participants said that fully itemised bills may hinder commercial confidences, and give away business practices with suppliers (levels of discount achieved for prosthesis for example).

Consultant information

- B.14 The OFT set out six provisional measures relating to information for consultants in order to elicit discussion amongst roundtable participants. These were:
- **Measure 4:** Greater amount of outcome and process measures relating to treatments conducted by individual consultants – especially for routine, elective treatments – made directly available to patients
 - **Measure 5:** Greater amount of outcome and process measures relating to individual consultants made available to GPs, PMI providers, PH providers and other relevant bodies (for example, Dr Foster) which can then be interpreted and conveyed to patients indirectly.
 - **Measure 7:** Consultants should be obliged to provide a fee estimate at or soon after first consultation in order to show an indicative price for treatment.
 - **Measure 8:** As part of a fee estimate, consultants should provide information to patients on how many times in specified time period they had requested a shortfall payment from a PMI-patient (across all PMI providers).

- **Measure 9:** Consultants should make their charges for a private patient first consultation more widely available so that patients know this – and can compare fees – prior to consultation.
- **Measure 10:** In the absence of express patient agreement to an anaesthetist fee which exceeds the benefit maxima, the amount of any shortfall incurred from the anaesthetist fee should be reimbursed by PH providers rather than PMI providers and/or PMI-funded patients.

Discussion summary

- B.15 **Outcome and Process Measures:** There was a significant degree of difference around the potential for developing comparable clinical indicators, especially those relating to outcomes. In general, concerns were voiced by consultant professional bodies about the difficulty in developing such data and the potential they created for distortion and misrepresentation if not valid (that is, a true representation of clinical quality). Specific issues considered included:
- **Difficult case-mixes:** Such cases hinder the use of outcome measures. A general criticism of outcome measures is that they fail to reflect how variations in clinical outcomes can be more influenced by the underlying health and severity of the patient's condition rather than quality of care provided by the clinician.
 - **Difficulty in selecting of outcome measures:** According to some participants, cardiothoracic surgery represented an exception to this due to the obviousness of the outcome (mortality) used.
 - **Outcomes based on patient expectations:** Some participants warned how patient expectations could differ markedly and questioned how closely associated these perceptions could be to the clinical performance of the consultant.
- B.16 **Volume Data:** Given the difficulties involved in developing comparable outcome and process measures for individual consultants, views were expressed about the use of other, more basic information regarding a consultant's work. For instance, some participants raised the idea of publishing the number and type of procedures undertaken by consultants in order to better inform patients and enable some comparison between

consultants. However, some participants questioned the usefulness of such data, highlighting that:

- volumes were low in private practice and this would hinder comparison
- volume data may discriminate against new consultants in particular, and
- established consultants tend to supervise treatments in the NHS rather than undertake them directly. This meant that volume data would not best represent the nature of their work and experience.

B.17 'Soft Information': Discussion also focused on softer types of information derived from patient experience of the consultant (questions relating to bedside manner, friendliness etc). Some participants said that many patients would value this sort of information, however other participants warned that such information, not being related to clinical factors, could unduly influence patients and impair the central function of the doctor (to treat the condition).

B.18 Fees: All participants recognised that the timeliness and clarity of information pertaining to cost is extremely important. A number of participants stressed that the current guidelines for consultants are clear in stressing the need for fees to be transparent and upfront. However, participants did recognise that variable practice may be seen amongst consultants in regard to the provision of fee estimates.

B.19 Complexity of PMI policies: Some participants noted that consultants, due to the multiplicity of PMI providers and PMI policies, are unable to advise patients on shortfalls as they are unaware of the fee schedule proscribed by each patient's insurance product. However, other participants noted that any such advice should be coupled with upfront transparency on fees (so patient could take a fee estimate to their PMI provider prior to treatment and receive advice on this).

B.20 Entire Episode Cost: Some participants noted that it was the entire treatment episode that was important and consultants should provide good information on costs of outpatient consultations / follow up care.

List of participants

B.21 32 participants met across the OFT's two roundtable discussions:

• Alliance Surgical	• Aspen Healthcare
• Association of Anaesthetists of GB & I (AAGBI)	• Aviva UK Health
• AXA PPP	• British Medical Association
• Bupa	• Care Quality Commission
• Circle	• Council for Healthcare Regulatory Excellence
• Department of Health	• Dr Foster
• Federation of Independent Practitioner Organisations (FIPO)	• GHG (BMI Healthcare)
• H5 Private Hospitals Alliance	• HCA
• Independent Doctors Federation	• Independent Healthcare Advisory Services (IHAS)
• King's Fund	• London Clinic
• National Association of Primary Care	• Nuffield Health
• Picker Institute	• PruHealth
• Ramsay Health Care UK	• Royal College of Surgeons
• Spire Healthcare	• St Anthony's Hospital
• The Horder Centre	• The Private Patients' Forum
• Which?	• WPA